SUBCHAPTER P. ADMINISTRATORS
28 TAC §7.1601 – §7.1618

1. INTRODUCTION. The Texas Department of Insurance proposes new §7.1601 - §7.1618, concerning administrators. The proposed new sections are necessary to implement House Bill (HB) 472, enacted by the 80th Legislature, Regular Session, effective September 1, 2007, which amends the Insurance Code Chapter 4151. The Department is simultaneously proposing the repeal of existing §7.1601 (relating to Definitions); §7.1602 (relating to Forms Relating to Regulation and Exemption of Administrators under the Insurance Code, Article 21.07-6); §7.1603 (relating to Application for Certificate of Authority); §7.1604 (relating to Application Denial, Suspension, Cancellation, or Revocation); §7.1605 (relating to Application Procedures); §7.1606 (relating to Exemption from Department Licensing and Regulation for Certain Administrators); §7.1607 (relating to Identification and Reporting Requirements for Certain Insurers and Health Maintenance Organizations); §7.1608 (relating to Fees); §7.1609 (relating to Prohibited Transactions); §7.1610 (relating to On-Site Visits); §7.1611 (relating to Cease and Desist Orders); §7.1612 (relating to Supplemental Information/Annual Report); §7.1613 (relating to Fidelity Bond); §7.1614 (relating to Maintenance Tax); §7.1615 (relating to Severability); §7.1616 (relating to Limited Certificate of Authority for Non-Texas-Licensed Third Party Administrators for Multi-Jurisdictional Impaired Insurance Companies Estate Administration); and §7.1617 (relating to School District Group Health Coverage

Contracts). The proposed repeal of these sections is also published in this issue of the *Texas Register*. This proposal includes new proposed sections to replace the repealed sections.

The following paragraphs generally discuss the significant changes to the Insurance Code Chapter 4151 as a result of HB 472. They also address the Department's proposed implementation of the reporting, oversight, and contracting requirements of the Insurance Code Chapter 4151. This general discussion is followed by a detailed section-by-section overview of the proposal.

Applicability of Proposed New Rules

HB 472 enacts a significant change to the Insurance Code Chapter 4151 that specifically affects a person providing administrative services in connection with workers' compensation benefits in this state. HB 472 amends the definition of the term *administrator* in the Insurance Code §4151.001(1) to include a person that in connection with workers' compensation benefits: (i) collects premiums or contributions from residents of this state; and/or (ii) adjusts or settles claims for residents of this state. Consequently, a person that provides these workers' compensation administrative services that was previously excluded from the requirements of the Insurance Code Chapter 4151 may now be subject to the Chapter 4151 requirements. Since the enactment of HB 472, the Department has received several inquiries regarding the applicability of the Insurance Code Chapter 4151 and the implementing rules. As a result, the Department has determined that it is necessary to clarify who is subject to the requirements of the

proposed new rules, while remaining consistent with the provisions of the Insurance Code Chapter 4151.

Proposed new §7.1601 specifies the scope and applicability of the proposed new rules. Proposed new §7.1601(a) provides that, except as otherwise provided by the Insurance Code Chapter 4151 or the proposed new rules, the proposed new rules apply to a person acting as or holding itself out as an administrator in any capacity. This applicability is regardless of whether the person holds another authorization pursuant to the Insurance Code or the Labor Code. The issue of whether a particular person is subject to the proposed new subchapter depends entirely upon whether the person is acting as or holding itself out as an administrator, as that term is defined in proposed new §7.1602(1). Proposed new §7.1602(1) incorporates the statutory definition of the term *administrator* that is in the Insurance Code §4151.001(1). Section 4151.001(1) defines an *administrator* as a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. Further, §4151.001(1) provides that the term includes: (i) a delegated entity under the Insurance Code Chapter 1272; and (ii) a workers' compensation health care network authorized under the Insurance Code Chapter 1305 that administers a workers' compensation claim for an insurer, including an insurer that establishes or contracts with the network to provide health care services. Lastly, §4151.001(1) states that the term does

not include a person described by the Insurance Code §4151.002. Thus, in order to determine whether a person meets the definition of the term *administrator* in proposed new §7.1602(1), it is necessary to evaluate the functions or services that the person is: (i) performing or providing; or (ii) offering to perform or provide. If the person qualifies for a specific exemption in the Insurance Code §4151.002, §4151.0021, or §4151.004, the person is not an administrator for the purpose of these proposed rules. However, if the person does not qualify for one of these exemptions, and the person collects or offers to collect premiums or contributions from residents of this state or adjusts, settles, or offers to adjust or settle claims for residents of this state, in connection with annuities or life, health, accident, pharmacy, or workers' compensation benefits, the person meets the definition of *administrator* in the Insurance Code §4001.001(1) and proposed new §7.1602(1). This is true, regardless of whether the person is also performing or providing other functions or services that subject the person to compliance with the Insurance Code and the Labor Code. Proposed new §7.1601(a) makes clear that a person acting as or holding itself out as an administrator may be simultaneously subject to the requirements of other provisions of the Insurance Code, the Labor Code, or rules adopted thereunder if the functions or services performed or offered by that person require such regulation. In such event, the person will be required to hold all appropriate authorizations pursuant to the Insurance Code or the Labor Code in order to perform or offer the regulated functions and services. This is because a single authorization issued pursuant to

the Insurance Code or the Labor Code does not authorize a person to perform or offer any additional regulated functions or services than those specified by the authorization. Each authorization relates to specific functions or services regulated under specific Insurance Code or Labor Code provisions. Therefore, a person must hold the applicable authorizations in order to perform or offer the corresponding regulated functions or services. The following example is provided for illustrative purposes. A person holds an authorization pursuant to the Insurance Code to operate a workers' compensation network in this state under the Insurance Code Chapter 1305. The person acts as or holds itself out as an administrator by settling a claim on behalf of the insurer that established or contracted with the network to provide health care services. In this example, the person will be simultaneously subject to the requirements of the Insurance Code Chapters 1305 and 4151 and the implementing rules. The person will be required to hold a separate authorization under each of these chapters in order to perform or provide the functions and services of a workers' compensation network and an administrator. This is because the authorization issued to the person under Chapter 1305 to operate a workers' compensation network in this state only authorizes the specific functions regulated under Chapter 1305. That specific authorization does not authorize the person to perform other activities that are regulated under other Insurance Code or Labor Code provisions. In order for the person to act as an administrator under the Insurance Code Chapter 4151, the person must hold a separate authorization issued pursuant to Chapter

4151. The person will be subject to the requirements of Chapter 1305 and the implementing rules for its functions related to operating a workers' compensation healthcare network. The person will also be simultaneously subject to the requirements of the Insurance Code Chapter 4151 and the implementing rules for acting as or holding itself out as an administrator. In order for the person to engage in each of these regulated activities, the person must hold separate authorizations issued under the applicable Insurance Code or Labor Code statutes and must comply with the rules adopted under each of those statutes. Proposed new §7.1601(c) further reinforces this requirement by providing that an administrator must meet the requirements of the Insurance Code Chapter 4151 and the proposed new rules in addition to any other requirements that apply to that person as: (i) a delegated third party of a health maintenance organization (HMO) under the Insurance Code Chapter 1272, (ii) a workers' compensation healthcare network under the Insurance Code Chapter 1305, (iii) a qualified claims servicing contractor under the Labor Code Chapter 407, or (iv) an administrator or service company under the Labor Code Chapter 407A.

Proposed new §7.1601(b) is necessary to effectuate the legislative intent of HB 472 by providing uniform application of the requirements of the Insurance Code Chapter 4151 to all administrators to which that chapter applies. As such, proposed new §7.1601(b) requires an administrator performing administrative services on behalf of an HMO pursuant to the Insurance Code Chapter 1272 or a workers' compensation self-insurance group (group) pursuant to the Labor Code

Chapter 407A to comply with the same requirements under the Insurance Code Chapter 4151 and the proposed new rules as an administrator performing administrative services on behalf of an insurer or plan sponsor. This will ensure that, to the extent possible, all administrators are treated equally under the Insurance Code Chapter 4151.

Proposed new §7.1601(d) makes clear that the proposed new rules do not apply to a person acting as or holding itself out as an administrator for an ERISA (The Employee Retirement Income Security Act of 1974) qualified employee welfare benefit plan that is exempt from regulation by this state. However, this exemption only applies with respect to the particular employee welfare benefit plan the person is administering. The following two examples are offered for illustrative purposes. In the first example, a person acts as or holds itself out as an administrator for several ERISA qualified employee welfare benefit plans offered by self-insured employers. The person, however, does not act as or hold itself out as an administrator for any other entity. Under proposed new §7.1601(d), the person will not be subject to the proposed new subchapter in any capacity, *provided that:* (i) each of the ERISA qualified employee welfare benefit plans for which the person acts as or holds itself out as an administrator is exempt from regulation by this state; and (ii) the person does not act as or hold itself out as an administrator for any other entity. In the second example, a person acts as or holds itself out as an administrator on behalf of an insurer and a group and for several ERISA qualified employee welfare benefit plans offered

by self-insured employers. In this example, proposed new §7.1601(d) clarifies that the person will not be subject to the proposed new rules with respect to the ERISA qualified employee welfare plans, *provided that* each of the ERISA qualified employee welfare benefit plans for which the person acts as or holds itself out as an administrator is exempt from regulation by this state. In this same example, however, the person will be subject to the requirements of the proposed new rules for acting as or holding itself out as an administrator on behalf of the insurer and the group. This is because, under proposed new §7.1601(d), the new rules are not applicable only to the extent that the administration of an ERISA qualified employee welfare plan that is exempt from state regulation is involved. The administration of any other type of plan offered, established, or maintained by any other type of entity is not exempt from compliance with the proposed new rules under §7.1601(d).

Administrator Contractors and Administrator Subcontractors

The term *administrator contractor* is defined in proposed new §7.1602(3). The term *administrator subcontractor* is defined in proposed new §7.1602(4). An administrator contractor may choose to delegate some or all of its administrative functions to an administrator subcontractor. Neither the Insurance Code Chapter 4151 nor the proposed new rules prohibit the delegation of an administrative service from one administrator to another. However, proposed new §7.1603(b) is necessary to clarify the responsibilities and obligations of an administrator contractor and an administrator subcontractor in situations where an

administrative service is delegated. Under proposed new §7.1603(b), both an administrator contractor and an administrator subcontractor are required to hold a certificate of authority under the Insurance Code Chapter 4151. This proposed new requirement is necessary to ensure appropriate oversight of all administrators regulated under the Insurance Code Chapter 4151. The more times that a particular function is delegated from one administrator to another, the greater the risk of non-performance or inadequate performance of that function. Additionally, because administrators are authorized under Chapter 4151 to (i) collect premium and contributions from Texas residents and (ii) adjust and settle claims for Texas residents, administrators often have access to and control of fiduciary bank accounts and other accounts designated for claims payment. While the authority of an administrator is largely determined by the particular person for which the administrator performs services, many administrators have great discretion in carrying out their delegated duties. Further, administrators often directly interact with Texas consumers, providers, physicians, staff members, and adjusters. Requiring all administrators, including administrator contractors and administrator subcontractors, to comply with the requirements of the Insurance Code Chapter 4151 and the proposed new rules will ensure appropriate oversight and more efficient regulation of all administrators. This should better protect the interests of the public and insurance consumers in this state.

Proposed Reporting Requirements

The Department is proposing new §7.1606, §7.1607, and §7.1609 to implement the reporting requirements enacted in HB 472. Proposed new §7.1606 and §7.1607 are necessary to implement the Insurance Code §4151.052(b). Section 4151.052(b) requires an applicant for a certificate of authority or a certificate holder (administrator) under the Insurance Code Chapter 4151 to notify the Department of a change of control in the applicant's or administrator's ownership or of any other fact or circumstance affecting the applicant's or administrator's qualifications for a certificate of authority. Section 4151.211 requires a person to seek approval from the Department in order to acquire an ownership interest resulting in a change of control of an administrator under Chapter 4151. Section 4151.211 also grants the Department the authority to disapprove a request for an acquisition of control. Further, if the Commissioner has not proposed to deny a request for an acquisition of control before the 61st day after the date on which the Department receives the required information, the request is deemed approved.

Proposed new §7.1606 prescribes notification requirements related to a change in control of an applicant or administrator. In order to clarify how the notification requirements apply to a change in control of an applicant or administrator, proposed new §7.1606(a) defines the meaning of term *control*; illustrates the manner in which control may be possessed; and describes when control exists for purposes of proposed new §7.1606. Section 7.1606(a) is necessary because proposed new §7.1606(b) requires an applicant or

administrator to notify the Department in writing of a change of control in the ownership of the applicant or administrator within a specified time frame. The §7.1606(b) notice requirement is triggered when there is a change in the control of an applicant or administrator, including a change in any of the circumstances specified in §7.1606(a). The additional guidance provided to applicants and administrators by proposed new §7.1606(a) should assist them in identifying reportable changes of control in their own organizations. Proposed new §7.1606(c) prohibits an applicant or administrator from filing the notification required by proposed new §7.1606(b) until a request for an acquisition of control has been approved under the Insurance Code §4151.211. This requirement is necessary to harmonize the provisions of the Insurance Code §4151.052(b) and §4151.211. Section 4151.052(b) requires an applicant or administrator to notify the Department of a change of control in the applicant's or administrator's ownership not later than the 30th day after the effective date of the change. However, §4151.211 prohibits a person from acquiring an ownership interest in an administrator unless the person has first filed specified information with the Department and the Department has approved the filed information. The harmonization provided by proposed new §7.1606(c) serves two important purposes. First, it provides the Department an opportunity to evaluate a requested acquisition of control of an applicant or administrator under the Insurance Code §4151.211 prior to the change taking place. The Department's review of a requested acquisition of control of an applicant or administrator is

essential to ensure that the proposed change does not impede the ability of the applicant or administrator to comply with the requirements of the Insurance Code Chapter 4151 or the proposed new rules. Further, it ensures that the proposed acquisition of control is appropriate and in the best interest of the public and the insurance consumers of this state. Proposed new §7.1606(c) also provides an opportunity to confirm whether an approved acquisition of control of an applicant or administrator actually occurs. This is necessary in order for the Department to remain informed of the significant changes in the operations of the applicant or administrator. This should result in more effective regulation of the applicant or administrator.

Proposed new §7.1607 is necessary to emphasize the importance of reporting material changes in facts and circumstances to the Department and maintaining continued compliance with the requirements of the Insurance Code Chapter 4151 and the proposed new rules. First, proposed new §7.1607(a) defines the phrase *material change in fact or circumstance.* It also provides a non-exhaustive list of examples of certain material changes in facts or circumstances that require notification to the Department under proposed new §7.1607(b) and (c). This sample list is provided to assist applicants and administrators in identifying specific changes in the facts or circumstances of their own organizations that require notification to the Department. Proposed new §7.1607(b) requires an administrator to notify the Department in writing of a material change in fact or circumstance within a specified time frame. This

required notification is necessary to provide the Department with the opportunity to evaluate the reported change in order to determine its likely effect on the administrator. Further, if the reported change in fact or circumstance adversely reflects upon the integrity of the administrator, the Department must be able to take any necessary action as quickly as possible in order to prevent any injury to the public and insurance consumers of this state. Except as provided by proposed new §7.1606(b), proposed new §7.1607(c) requires an applicant to continually update the information filed in its initial application for a certificate of authority. This includes notifying the Department in writing of a material change in fact or circumstance, while the application is pending with the Department. This required notification is necessary to allow the Department to accurately assess an applicant's fitness for licensure. Further, if a reported change in the information filed in an applicant's initial application for a certificate of authority prevents an applicant from fulfilling the minimum requirements necessary for the Department to approve its application, the Department must be able to identify and assess those situations quickly and accurately. Proposed new §7.1607(d) and (e) are necessary to address an applicant's or administrator's continued compliance with the requirements of the Insurance Code Chapter 4151 and the proposed new rules. Proposed new §7.1607(d) requires an applicant or administrator to meet the requirements of Chapter 4151 and the proposed new rules as those requirements apply to any material change in fact or circumstance identified by an administrator pursuant to proposed new §7.1607(b) and to any

change in information identified by an applicant pursuant to proposed new §7.1606(c). Proposed new §7.1607(e) requires an applicant and an administrator to maintain the qualifications necessary to obtain a certificate of authority under Chapter 4151 at all times. These proposed new requirements ensure that an applicant and an administrator maintain the integrity of their organizations by meeting the minimum statutory and regulatory requirements applicable to their organizations at all times. This includes when certain facts and circumstances affecting those organizations change over time. Requiring all applicants and administrators to continually monitor their own organizations for compliance with applicable statutory and regulatory requirements will help ensure the financial health and integrity of the administrators in this state.

Proposed new §7.1609 is necessary to implement the annual reporting requirements of HB 472 and to clarify the Insurance Code §4151.205(f). Proposed new §7.1609(a), (b), and (c) are necessary to prescribe the general requirements that apply to annual report filings under the Insurance Code §4151.205. Proposed new §7.1609(d) is necessary to clarify the exemption provided by the Insurance Code §4151.205(f) and to establish the certification requirements prescribed by the Insurance Code §4151.205(f). HB 472 amends the Insurance Code §4151.205(a) to require an administrator to file an annual report no later than June 30 each year with the Commissioner. Pursuant to the Insurance Code §4151.205(a) – (d), the annual report must: (i) cover the preceding calendar year; (ii) include an audited financial statement performed by

an independent public accountant; and (iii) include notes or attachments to the financial statement that reflect the complete name and address of each insurer in this state with which the administrator had an agreement during the preceding fiscal year. The Insurance Code §4151.205(f) exempts an administrator who meets certain conditions from filing the audited financial statement required by §4151.205(c). Section 4151.205(c) requires the exempted administrator to file a financial statement with the Commissioner, certified in the manner prescribed by Commissioner rule.

After the enactment of HB 472, the Department received inquiries regarding the applicability of the exemption allowed by the Insurance Code §4151.205(f). As a result, the Department is proposing new §7.1609(d)(1) to clarify that the exemption in the Insurance Code §4151.205(f) applies only to compensation received by an administrator for providing administrative services *in Texas* during the preceding calendar year. Thus, an administrator may qualify for the exemption in proposed new §7.1609(d)(1) if the administrator earns less than $10 million in compensation for providing administrative services *in Texas*, regardless of the amount of compensation the administrator earns for providing administrative services in other jurisdictions. Proposed new §7.1609(d)(1) is necessary to provide small administrators and administrators with limited business in Texas the less costly option of filing a certified financial statement with the Department instead of an audited financial statement performed by an independent public accountant as part of their annual report. Of the 751

administrators currently licensed by the Department, the Department estimates that 734 may qualify for the exemption in proposed new §7.1609(d)(1) and may be eligible to utilize that option for the annual report filing due June 30, 2009. By providing a less costly filing option for these administrators, the Department anticipates that many of these administrators may be able to realize additional cost savings. Although proposed new §7.1609(d)(1) provides an exemption from the financial filing requirements of proposed new §7.1609(c) for certain qualifying administrators, the Department's ability to effectively regulate these qualifying administrators will not be negatively affected by the use of this exemption. In an effort to maintain effective regulation of these administrators and to ensure that all necessary financial information is timely filed with the Department, the Department is proposing new §7.1609(d)(2) and (3). Proposed new §7.1609(d)(2) requires an administrator qualifying for the exemption in §7.1609(d)(1) to file an alternative financial statement with the Department that includes a certification form and is verified by at least two officers or other comparable responsible persons of the administrator. The certification form is adopted by reference in proposed new §7.1609(b)(1)(D) as Form Number FIN 490, Certification of Financial Statement, and prescribes the text and format of the required certification: This proposed requirement is important for several reasons. First, proposed new §7.1609(d)(2) makes clear that no administrator is completely exempt from filing a financial statement with the Department. While compliance with the requirements of proposed new §7.1609(d)(2) may be less

costly or less onerous than compliance with the requirements of proposed new §7.1609(c), an administrator qualifying for the exemption in proposed new §7.1609(d)(1) is nonetheless required to file a sufficient financial statement with the Department under proposed new §7.1609(d)(2). This minimum threshold enables the Department to exercise appropriate oversight over the financial health of an administrator qualifying for the exemption in proposed new §7.1609(d)(1). Second, proposed new §7.1609(d)(2) requires at least two officers or other comparable responsible persons of an administrator qualifying for the exemption to execute a notarized certification and to verify the financial statement filed with the Department. This proposed requirement helps to ensure that the financial statements submitted to the Department are properly prepared, reviewed, and verified. Additionally, proposed new §7.1609(d)(2) requires some involvement and oversight from the responsible persons of the administrator. This should result in more efficient management of the administrator. Further, proposed new §7.1609(d)(3) requires that an administrator qualifying for the exemption in proposed new §7.1609(d)(1) meet all other requirements of proposed new §7.1609. This proposed requirement enables the Department to appropriately review the overall operating condition of an administrator, including its financial strength, claims payment history, account management, and compliance with applicable statutes, rules, and contract provisions, regardless of the type of financial statement filed by the administrator as part of its annual report. Proposed new §7.1609(e) provides that the Commissioner may request

additional information as necessary to determine if an administrator is operating or conducting business in a potentially hazardous or injurious manner. This proposed new requirement is necessary to enable the Department to earlier detect an administrator's potentially hazardous or injurious operating condition. HB 472 enacts §4151.301(8), which permits the Department to take appropriate action to address situations in which an administrator is in a financial condition or is operating or conducting business in a manner that would render further transaction of business in this state hazardous or injurious to the public or insurance consumers of this state. The proposed new requirement is important in ensuring that corrective actions can be taken to alleviate or prevent harm to the public and insurance consumers of this state as a result of an administrator's hazardous or injurious operating condition at the earliest possible point in time.

Proposed Oversight Requirements

While the use of administrators may provide insurers, HMOs, plan sponsors, and groups with cost savings and access to persons with specialized claims payment and management skills, it also presents special challenges. The authority of an administrator is largely determined by the particular insurer, HMO, plan sponsor, or group that has delegated duties to the administrator. As a result, many administrators are given wide discretion in carrying out their delegated duties. Depending upon each insurer's, HMO's, plan sponsor's, or group's individual preference, an administrator may perform a wide variety of statutorily required duties on behalf of the insurer, HMO, plan sponsor, or group.

Administrators are often delegated the responsibility of timely paying medical benefits and workers' compensation benefits on behalf of insurers, HMOs, plan sponsors, and groups. Many administrators also have control over an insurer's, HMO's, plan sponsor's, or group's books and records and claims files. While such delegation of discretion may be appropriate in many instances, the monitoring and oversight of these administrators is essential in ensuring their compliance with applicable statutes, rules, and contract provisions for the functions they perform. New §7.1611, §7.1612, §7.1615, and §7.1616 are proposed to address the monitoring and oversight of administrators.

First, proposed new §7.1611 is necessary to implement the review and on-site audit requirements of the Insurance Code §4151.1042. HB 472 enacts the Insurance Code §4151.1042, which requires an insurer to ensure competent administration of its programs. Further, the Insurance Code §4151.1042 requires an insurer to conduct a semi-annual review of the operations of each of its administrators that, on the insurer's behalf, administers benefits for more than 100 certificate holders, injured employees, plan participants, or policyholders. Additionally, the Insurance Code §4151.1042 requires an insurer to conduct a biennial on-site audit of the operations of each of its administrators that, on the insurer's behalf, administers benefits for more than 100 certificate holders, injured employees, plan participants, or policyholders. The proposed new requirements of §7.1611 impose a minimal level of oversight and responsibility on each insurer that utilizes the services of an administrator. These proposed

new requirements are significant because an insurer retains the ultimate responsibility and accountability for each function it delegates to an administrator. Thus, it is imperative that an insurer appropriately monitor the activities of its administrators to ensure their compliance with the Insurance Code, the Labor Code, and rules adopted thereunder. An insurer's regular oversight over its administrators is important. Therefore, proposed new §7.1611(a) requires an insurer, no less than two times each fiscal year, to review the operations of each of its administrators that, in the aggregate, administers benefits in Texas on its behalf for more than 100 certificate holders, injured employees, plan participants, or policyholders. Additionally, proposed new §7.1611(b) requires an insurer, no less than once every two fiscal years, to conduct an on-site audit of each of its administrators that, in the aggregate, administers benefits in Texas on its behalf for more than 100 certificate holders, injured employees, plan participants, or policyholders. Proposed new §7.1611(d) and (e) prescribe the minimum information that an insurer should review during the required review or on-site audit. This includes a review of an administrator's compliance with the contract between the administrator and the insurer and the administrator's performance of claims adjudication and payment. The proposed new requirements also require an insurer to develop a written summary of the objectives and scope of the review or on-site audit and a summary of the results of the review or on-site audit. Each summary must include a corrective action plan addressing any deficiencies found during the review or on-site audit. These proposed new

requirements are important for several reasons. First, reviewing the prescribed information should enable an insurer to better assess its ability to meet its obligations under the Insurance Code, Labor Code, and rules adopted thereunder. Additionally, it is anticipated that an insurer's regular review of the required information will enable the insurer to foresee potential financial problems or solvency issues at a much earlier date, so that corrective action can be taken immediately. Further, proposed new §7.1611 emphasizes the importance of establishing performance goals for administrators and reviewing the performance of the administrators to determine if those goals are being met. By regularly monitoring and overseeing its administrators, an insurer should obtain a better idea of its own capabilities, strengths, and weaknesses. This should result in financially healthier insurers. Additionally, if an insurer already has an audit plan in place to oversee its administrators, it may already meet several of the proposed new requirements. In these situations, an insurer must only ensure that its current audit plan is modified to address the proposed new requirements that are not currently being addressed in its audit plan.

Administrative services are sometimes delegated from one administrator to another. Neither the Insurance Code Chapter 4151 nor the proposed new subchapter prohibits such a re-delegation of administrative services. However, an insurer remains ultimately responsible for the performance of all of its delegated functions, regardless of whether those functions are performed by an administrator contractor or by an administrator subcontractor. As is previously

discussed in this proposal, in a situation where an administrator contractor further delegates the performance of its administrative functions to an administrator subcontractor, both the administrator contractor and the administrator subcontractor qualify as an administrator under proposed new §7.1602(1). In such situations, because the administrator contractor and the administrator subcontractor are both performing delegated functions on behalf of an insurer, it is necessary for the insurer to regularly monitor and oversee the activities of both the administrator contractor and the administrator subcontractor. An insurer remains responsible for monitoring and overseeing the activities of all of its administrators, including its administrator contractors and administrator subcontractors. However, it may be appropriate for the administrator contractor that delegates the performance of a specific function to an administrator subcontractor to oversee the performance of that administrator subcontractor on the insurer's behalf. Therefore, proposed new §7.1611(g) provides an insurer with the option of meeting the §7.1611 monitoring and oversight requirements for an administrator subcontractor by reviewing and auditing its administrator contractor only. However, an insurer may utilize this option *only if* two requirements are met. First, an administrator contractor must supply the insurer with all the necessary and relevant information relating to a particular administrator subcontractor. Second, the information provided to the insurer by the administrator contractor must indicate that no evidence of material non-compliance by the administrator subcontractor exists. If these two requirements

are met, an insurer may utilize the option provided by proposed new §7.1611(g). However, if these two requirements are not met, an insurer must review and audit each of its non-compliant administrator subcontractors in accordance with the §7.1611 review and audit requirements for its administrator contractors. Proposed new §7.1611(g) serves two important purposes. First, the insurer is requiring its administrator contractors to take an active role in ensuring that each administrator subcontractor performs its delegated administrative functions professionally, competently, and in compliance with all applicable statutes, rules, and contract provisions. Second, the insurer may be able to realize the benefit of consolidating the review of all of its administrators. A consolidated review may result in cost savings for the insurer while still ensuring an appropriate level of oversight of all administrators.

Because administrators are authorized under the Insurance Code Chapter 4151 to collect premiums, contributions, return premiums, and return contributions (premiums) from residents of this state, proposed new §7.1612 prescribes requirements intended to provide additional oversight over the administrators that collect these premiums. First, pursuant to the Insurance Code §4151.106, proposed new §7.1612 requires an administrator to hold all premium in a fiduciary capacity. This proposed requirement is necessary to implement the fiduciary duty requirement imposed by the Insurance Code §4151.106(b) upon an administrator that collects premiums on behalf of an insurer, HMO, plan sponsor, or group. Second, proposed new §7.1612

prescribes the general requirements related to the establishment and maintenance of fiduciary accounts used to hold collected premiums. For example, proposed new §7.1612(e) requires an administrator to maintain a fiduciary bank account at a financial institution that is organized under the laws of the United States. It must also be regulated under the laws of United States federal or state authorities having regulatory authority over banks and trust companies. This proposed requirement is necessary to ensure that collected premiums are maintained in an accessible, stable, and secure environment at all times. Further, proposed new §7.1612(e) permits a fiduciary bank account to consist only of one or more of the following types of investments: (i) cash and cash equivalents; (ii) non-assessable money market mutual funds that are primarily invested in United State government securities; and (iii) other investments of substantially similar quality, as approved by the Commissioner. This proposed requirement is necessary to preserve the integrity and stability of collected premiums and to ensure immediate access to those premiums, should such access be required.

The remaining provisions of proposed new §7.1612 generally relate to certain, specified administrator activities. Proposed new §7.1612(f) requires an administrator to properly maintain detailed accounting records documenting all deposits and withdrawals from a fiduciary account. This proposed requirement ensures that each collected premium is properly accounted for and transferred to the appropriate insurer, HMO, plan sponsor, or group. Proposed new §7.1612(g)

requires an administrator to provide a copy of the records relating to the account activity of an insurer, HMO, plan sponsor, or group in a fiduciary bank account to the insurer, HMO, plan sponsor, or group, upon its reasonable request. This proposed requirement is necessary to provide an insurer, HMO, plan sponsor, or group with continuing access to a fiduciary account maintained by an administrator on its behalf. This enables the insurer, HMO, plan sponsor, or group to properly oversee the activities of the administrator and to ensure that the premiums collected on its behalf are properly accounted for and maintained. Finally, proposed new §7.1612(i) prohibits an administrator from paying a claim from a fiduciary bank account, which is consistent with the statutory prohibition in the Insurance Code §4151.109. It further ensures that all collected premiums are maintained in fiduciary accounts that are separate and distinguishable from any account used by an administrator to pay a claim on behalf of an insurer, HMO, plan sponsor, or group.

Depending upon the duties that an administrator performs on behalf of an insurer, HMO, plan sponsor, or group, an administrator may have access to, or control over, the books and records of an insurer, HMO, plan sponsor, or group. In such situations, it is necessary for the insurer, HMO, plan sponsor, or group to have continuing access to its books and records, even while the books and records are in the possession of an administrator. The Department is aware of situations where administrators have refused to timely return the books and records of an insurer or have denied an insurer access to its own books and

records altogether. These situations typically involved an insurer that terminated the employment of one administrator in order to employ the services of another administrator. These situations also usually occurred when there was an inadequate written agreement between the parties, or where the written agreement between the parties did not sufficiently address transition and ownership issues. An administrator's refusal to provide an insurer, HMO, plan sponsor, or group with access to its own books and records can have disastrous and widespread results, especially with regard to the payment of claims. An insurer, HMO, plan sponsor, or group simply cannot comply with the requirements of the Insurance Code, the Labor Code, and rules adopted thereunder without knowing which of its claims has been paid and which of its claims remain outstanding. Additionally, an insurer, HMO, plan sponsor, or group may be put into a potentially hazardous financial condition if it is unable to access its financial books and records. New §7.1615 is proposed in an effort to prevent these situations from occurring. It addresses the continuity of services and ownership of books and records. Further, proposed new §7.1615 is necessary to implement the Insurance Code §4151.103(d). Section 4151.103(d) provides that the Commissioner shall adopt rules to address the transfer of records from one administrator to another. The proposed new requirements are also necessary to ensure that an insurer, HMO, plan sponsor, or group retains continual access to its own books and records following the termination of its relationship with an administrator. First, proposed new §7.1615(a) requires an

administrator to provide a complete and accurate original set or a complete and accurate copy or image of the original set of an insurer's, HMO's, plan sponsor's, or group's books and records to a successor administrator. If there is not a successor administrator or the successor administrator is unknown at the time of the required transfer, then they must be provided to the insurer, HMO, plan sponsor, or group. In both cases, the books and records must be provided no later than 30 days from the date of the termination of the relationship or written agreement between the insurer, HMO, plan sponsor, or group and the administrator, unless otherwise approved by the Commissioner. Proposed new §7.1615(b) requires the books and records to be transferred in an organized and usable manner. These proposed new requirements are designed to prevent potentially hazardous financial conditions from occurring during transition periods and to alleviate delays in claims payments. Proposed new §7.1615(d) requires an administrator to provide written notice to the Department of the termination of a relationship or written agreement with an insurer, HMO, plan sponsor, or group no later than thirty days from the date the administrator first learns of the termination. This proposed new requirement provides the Department with the opportunity to monitor specific transition periods to ensure that claims are timely paid, premiums are appropriately collected and transferred, and the financial condition of insurers, HMOs, plan sponsors, groups, and administrators remain stable. Proposed new §7.1615(e) is necessary to address situations where an administrator contractor has further delegated the performance of its

administrative duties to an administrator subcontractor. In these situations, it is likely that the administrator contractor will have provided the administrator subcontractor with a portion of the books and records of the insurer, HMO, plan sponsor, or group so that the administrator subcontractor may appropriately perform its delegated duties. As is previously discussed in this proposal, in a situation where an administrator contractor further delegates the performance of its administrative functions to an administrator subcontractor, both the administrator contractor and the administrator subcontractor qualify as an administrator under proposed new §7.1602(1). As such, the requirements of proposed new §7.1615 apply equally to the administrator contractor and the administrator subcontractor. However, the termination of the relationship between an administrator contractor and an administrator subcontractor may not necessarily affect the relationship between the administrator contractor and the insurer, HMO, plan sponsor, or group. In such situations, it may be appropriate for the administrator contractor to retain its relationship with the insurer, HMO, plan sponsor, or group and to re-delegate the performance of certain delegated functions to a new administrator subcontractor. Therefore, when an administrator subcontractor's relationship or written agreement with an administrator contractor terminates, proposed new §7.1615(e) provides the administrator subcontractor with an option. The administrator subcontractor may comply with the requirements of proposed new §7.1615 by providing a complete and accurate original set or a complete and accurate copy or image of the

original set of the insurer's, HMO's, plan sponsor's, or group's books and records to the administrator contractor. The administrator subcontractor must also provide written notice to the Department of the termination of the relationship or written agreement with the administrator contractor, no later than thirty days from the date the administrator subcontractor first learns of the termination. This proposed requirement serves two important purposes. First, it ensures that the administrator contractor maintains possession over the books and records that were originally provided to the administrator subcontractor on the insurer's, HMO's, plan sponsor's, or group's behalf. Second, it allows the administrator contractor the opportunity to re-delegate the performance of certain delegated functions to another administrator subcontractor, should it choose to do so. Should an administrator subcontractor choose not to utilize the option provided by proposed new §7.1615(e), then that administrator subcontractor is required to meet the requirements of proposed new §7.1615 in the same manner that an administrator contractor is required to meet the requirements of proposed new §7.1615.

Finally, proposed new §7.1616 addresses circumstances which may indicate that an applicant or administrator is operating in a potentially hazardous or injurious manner. HB 472 enacts the Insurance Code §4151.301(8). This statute permits the Department to take appropriate action if an applicant or administrator is in a financial condition or is operating or conducting business in a manner that would render further transaction of business in this state hazardous

or injurious to the public or insurance consumers of this state. The proposed new requirements are important in identifying applicants' and administrators' potentially hazardous or injurious conditions so that corrective actions, if necessary, may be taken to alleviate or prevent harm to the public and insurance consumers of this state at the earliest point in time. Proposed new §7.1616(a) provides eight illustrative examples of conduct that may indicate that an applicant or administrator is operating or conducting business in a potentially hazardous or injurious manner. These examples, however, are not exhaustive. Proposed new §7.1616(b) makes clear that other facts and circumstances that are not specified in the eight examples may also indicate that an applicant or administrator is operating in a potentially hazardous or injurious manner. Further, the conditions specified in proposed new §7.1616(a) do not *necessarily* indicate that an applicant or administrator is operating in a potentially hazardous or injurious manner. Rather, they are conditions that may be considered by the Department in determining whether an applicant or administrator is operating in a potentially hazardous or injurious manner. For example, if an applicant or an administrator fails to file a financial statement with the Department as illustrated in proposed new §7.1616(a)(1), the Department may contact the applicant or administrator and request additional information. Based upon the applicant's or administrator's response to the Department, the Department may further investigate the situation to determine if any preventative or correction action is needed or the Department may determine that the issue has been resolved. A final determination of

whether an applicant or administrator is operating in a potentially hazardous or injurious manner may depend upon many factors, including one or more factors enumerated in proposed new §7.1616. However, a final determination of whether an applicant or administrator is operating in a potentially hazardous or injurious manner is not *necessarily* dependent upon a factor enumerated in proposed new §7.1616. Proposed new §7.1616 is intended to provide applicants and administrators guidance in managing their own organizations. By providing applicants and administrators with illustrative examples of situations that may constitute or lead to potentially hazardous or injurious operating conditions, the Department anticipates that applicants and administrators will take preventative steps to avoid these types of situations. This should result in healthier and more stable applicants and administrators.

Proposed Contracting Requirements

Because an insurer retains ultimate responsibility and accountability for the functions performed by its administrators, it is imperative that each insurer monitor the activities of its administrators and maintain appropriate oversight over its administrators. Therefore, new §7.1613 is proposed to establish minimum contracting requirements between an insurer and an administrator. It requires each administrator performing administrative services in Texas on behalf of an insurer to enter into a written agreement with that insurer. Proposed new §7.1613(c), (d), (e), and (f) prescribe the minimum requirements, obligations, and provisions that must be included in each written agreement between an insurer

and an administrator. These proposed new requirements are necessary for several reasons. First, under the proposed new requirements, insurers are required to establish written expectations for their administrators. This proposed requirement is necessary to ensure that each party clearly understands their responsibilities and obligations under the written agreement. Further, it is easier for an insurer to monitor its administrators to determine if they are performing their delegated functions in accordance with the expectations of the insurer once those expectations have been memorialized in a written agreement. Second, the proposed new requirements require insurers and administrators to address compliance with other important proposed new requirements of the subchapter in their written agreement. This includes the obligation of an insurer to review and audit its administrators under proposed new §7.1611 and the obligation of an administrator to notify the Department and timely transfer the books and records of an insurer upon the termination of the relationship with the insurer under proposed new §7.1615. It is especially important for an insurer and an administrator to address these matters in their written agreements because of the complexity and potential complications related to these issues. Finally, as previously discussed in this proposal, in a situation where an administrator contractor further delegates the performance of its administrative functions to an administrator subcontractor, both the administrator contractor and the administrator subcontractor qualify as an administrator under proposed new §7.1602(1). As such, the requirements of proposed new §7.1613 apply equally

to the administrator contractor and the administrator subcontractor. However, an administrator contractor may delegate a few, specific duties to an administrator subcontractor and may retain a contractual responsibility for the performance of those duties, despite the delegation of those duties to the administrator subcontractor. Additionally, some insurers may permit their administrator contractors to further delegate duties to administrator subcontractors, provided that the administrator contractors retain responsibility for the performance of those duties. As previously stated, each insurer retains the ultimate responsibility for all of its delegated duties, regardless of whether they are performed by an administrator contractor or an administrator subcontractor. It may be appropriate, however, in some instances for an administrator contractor to enter into a written agreement with an administrator subcontractor for the performance of certain delegated duties without the insurer entering into a separate written agreement with that particular administrator subcontractor. In these instances, the insurer is required to enter into a written agreement with the administrator contractor pursuant to proposed new §7.1613(a). Therefore, proposed new §7.1613(b) provides an administrator subcontractor with the option of meeting the contracting requirements of proposed new §7.1613 by entering into a written agreement with an administrator contractor only. This is permissible only if the written agreement meets the requirements of the Insurance Code Chapter 4151 and proposed new §7.1613. This gives insurers the flexibility of entering into a written agreement with an administrator contractor

and permits that administrator contractor to further delegate certain duties to an administrator subcontractor without the insurer having to enter into a separate agreement with the administrator subcontractor. This option is particularly useful when the duties performed by the administrator subcontractor are limited in scope. Because of the insurer-administrator contractor written agreement required under proposed new §7.1613(a), the insurer will be able to oversee the administrator contractor and monitor its activities. Further, proposed new §7.1613(b) will enable the administrator contractor to oversee and monitor the performance of each of its administrator subcontractors through the written agreement that the administrator contractor has with each administrator subcontractor. This approach is intended to ensure that each administrator, whether an administrator contractor or an administrator subcontractor, is properly monitored by another responsible person. Should an administrator subcontractor choose not to utilize the option provided by proposed new §7.1613(b), then that administrator subcontractor is required to meet the requirements of proposed new §7.1613 in the same manner that an administrator contractor is required to meet the requirements of proposed new §7.1613.

Application, Annual Report, and Exam Fees

Proposed new §7.1604(b)(2) proposes the adoption of a non-refundable application filing fee of $1,000. The Insurance Code §4151.206(a)(1) provides that an applicant or administrator shall pay, in an amount to be determined by the Commissioner, a filing fee not to exceed $1,000 for processing an original

application for a certificate of authority. The Department has determined that the proposed new application fee amount is appropriate and necessary for the following reasons: (i) the proposed new application fee amount is needed to offset the Department's costs for processing and reviewing administrator applications, including the new applications that will be required annually as a result of HB 472; (ii) the Department has not increased the current application fee amount since 1990, although the Department's responsibilities for the general administration of Chapter 4151 and the costs for reviewing and processing administrator applications have increased since that time; and (iii) the new application fee amount is more consistent with other fee amounts charged by the Department for reviewing and processing other applications and issuing other authorizations.

Proposed new §7.1609(b)(2) proposes the adoption of a non-refundable annual report filing fee of $200. This fee must accompany the annual report required to be filed by the administrator no later than June 30 each year. The Insurance Code §4151.206(a)(3) provides that an administrator shall pay, in an amount to be determined by the Commissioner, a filing fee not to exceed $200 for an annual report. The Department has determined that the proposed new annual report fee amount is appropriate and necessary for the following reasons: (i) the proposed new annual report fee amount is needed to offset the Department's costs for processing and reviewing administrator annual reports, including the new reports that will be required annually as a result of HB 472; (ii)

the Department has not increased the current annual report fee amount since 1990, although the Department's responsibilities for the general administration of Chapter 4151 and the Department's costs for reviewing and processing administrator annual reports have increased since that time; and (iii) the proposed new annual report fee amount is more consistent with other fees charged by the Department for reviewing and processing other entity's annual reports.

Proposed new §7.1617(a) proposes the adoption of a non-refundable examination fee of $500, as authorized by the Insurance Code §4151.206(a)(2). The Insurance Code §4151.206(a)(2) provides that an administrator shall pay, in an amount to be determined by the Commissioner, a fee not to exceed $500 for an examination under the Insurance Code §4151.201. The Department has determined that the proposed new examination fee amount is appropriate and necessary for the following reasons: (i) the proposed new exam fee amount is needed to offset the Department's costs for examining an administrator, including workers' compensation administrators that are now subject to examination under Chapter 4151; (ii) the Department has not increased the current exam fee amount since 1990, although the Department's costs for examining an administrator are likely to exceed that fee amount; and (iii) the proposed new exam fee amount is still substantially less than other examination fees charged by the Department for conducting examinations of other entities.

Section-by-Section Overview. The following is a section by section overview of the proposal. Proposed new Subchapter P in Chapter 7 of Title 28 of the Texas Administrative Code consists of proposed new §7.1601 – §7.1618.

§7.1601. Scope.

Proposed new §7.1601(a) specifies that, except as otherwise provided by the proposed new subchapter or the Insurance Code Chapter 4151, the proposed new subchapter applies to a person acting as or holding itself out as an administrator in any capacity, regardless of whether the person holds another authorization under the Insurance Code or the Labor Code. In accordance with the Insurance Code §1272.058 and the Labor Code §407A.009, proposed new §7.1601(b) requires an administrator performing administrative services on behalf of an HMO or a group to meet the same requirements under the Insurance Code Chapter 4151 and the proposed new subchapter as an administrator performing administrative services on behalf of an insurer or plan sponsor. Proposed new §7.1601(c) requires a person acting as or holding itself out as an administrator to meet the requirements of the Insurance Code Chapter 4151 and the proposed new subchapter. This is in addition to any other requirements applicable to that person under the Insurance Code Chapters 1272 or 1305 or the Labor Code Chapters 407 or 407A and rules adopted thereunder. Proposed new §7.1601(d) clarifies that the proposed new subchapter does not apply to a person acting as or holding itself out as an administrator for an ERISA qualified

employee welfare benefit plan that is exempt from regulation by this state with respect to that particular employee welfare benefit plan.

§7.1602. Definitions. Proposed new §7.1602 defines the terms used in the proposed new subchapter.

§7.1603. Certificate of Authority Required. Proposed new §7.1603(a) requires each person acting as or holding itself out as an administrator to hold a certificate of authority under the Insurance Code Chapter 4151, unless the person meets an exemption under that chapter. Proposed new §7.1603(b) requires an administrator contractor and an administrator subcontractor to hold a certificate of authority under the Insurance Code Chapter 4151.

§7.1604. Application for Certificate of Authority. Proposed new §7.1604(a) requires an applicant for a certificate of authority under Chapter 4151 to file an application with the Department, accompanied by a non-refundable fee of $1,000. Proposed new §7.1604(a) also requires the applicant to verify the application by attesting to the truth and accuracy of the information in the application. Proposed new §7.1604(b)(1) adopts by reference the following forms, which comprise the application for a certificate of authority under the Insurance Code Chapter 4151. These forms are available at www.tdi.state.tx.us/forms/form5tpa.html: (i) Form Number FIN 489, Application for a Certificate of Authority; (ii) Form Number FIN 306, Officers and Directors; (iii) Form Number LHL 081, Biographical Affidavit; and (iv) Form Number LHL 082, Service of Process. Proposed new §7.1604(b)(2) specifies that as

authorized by the Insurance Code §4151.206(a)(1), the Commissioner adopts a filing fee of $1,000 to be paid by an applicant for processing an original application for a certificate of authority for an administrator. Proposed new §7.1604(c) requires an applicant to register its official name with the Department and the Office of the Secretary of State, as applicable. Additionally, proposed new §7.1604(c) specifies that an applicant must register an alternative name with the Department and the Office of the Secretary of State, as applicable, if the Commissioner determines that an applicant's name is too similar to a name already registered with the Department. Proposed new §7.1604(d)(1) requires each executive officer or other comparable responsible person of an applicant to provide the Department with a completed Form Number LHL 081, Biographical Affidavit. Proposed new §7.1604(d)(1) also specifies that a biographical affidavit is not required if a biographical affidavit from the individual has been filed with the Department within the prior three years and contains substantially accurate information. Further, proposed new §7.1604(d)(1) clarifies that a biographical affidavit contains substantially accurate information if the responses given by the individual in the affidavit on file with the Department continue to indicate sufficient experience, ability, standing, and good record to make success of the applicant probable. Proposed new §7.1604(d)(2) requires each person filing a biographical affidavit under proposed new §7.1604(d)(1) to comply with the requirements of Chapter 1, Subchapter D of Title 28 of the Texas Administrative Code. Pursuant to the Insurance Code §4151.052(a)(5), proposed new §7.1604(e) provides that

the Commissioner may require the submission of any other information the Commissioner reasonably requires in determining whether to approve or disapprove an application for a certificate of authority.

§7.1605. Notification Requirements. Proposed new §7.1605(a) specifies that an insurer or HMO that is acting as or holding itself out as an administrator and that is not exempt under the Insurance Code §4151.002(3) or (4) is subject to all provisions of the proposed new subchapter, except proposed new §7.1603, §7.1604, and §7.1609(c) and (d)(1) and (2) (relating to Certificate of Authority Required, Application for Certificate of Authority, and Annual Report). Proposed new §7.1605(b) requires an insurer or HMO meeting the requirements of proposed new §7.1605(a) to submit written notice to the Department that it will be acting as or holding itself out as an administrator. Proposed new §7.1605(b) further requires such notice to include the insurer's or HMO's contact information. This includes: (i) the insurer's or HMO's TDI company number; (ii) a narrative describing the insurer's or HMO's facilities, personnel, and experience relating to the functions the insurer or HMO will be performing as an administrator; and (iii) a list of any other states in which the insurer or HMO will be acting as or holding itself out as an administrator.

§7.1606. Requirements Related to Ownership Interest and Change of Control. The provisions of proposed new §7.1606(a)(1) – (3) relate to a change in the *control* of an applicant or administrator. The three provisions are for purposes of proposed new §7.1606 only and for no other purposes. Proposed

new §7.1606(a)(1) provides that *control* means the power to direct, or cause the direction of, the management and policies of a person, other than the power that results from an official position with or corporate office held by the person. Proposed new §7.1606(a)(2) provides that *control* may be possessed by various means, including through ownership of voting securities, ownership by contract, or direct or indirect control of one or more persons that control an administrator. Proposed new §7.1606(a)(3) provides that *control* exists if an individual or a member of an individual's immediate family, directly or indirectly, owns, controls, or holds with the power to vote 10 percent or more of the voting securities or authority of an administrator or another person that directly or indirectly controls an administrator, including when a person holds proxies representing 10 percent or more of the voting securities or authority of the person. Pursuant to the Insurance Code §4151.052(b), proposed new §7.1606(b) requires an applicant or an administrator to notify the Department in writing of a change of control in the ownership of the applicant or the administrator not later than the 30th day after the effective date of the change. The §7.1606(b) notice requirement applies to any instance in which there is a change in the control of an applicant or administrator, including a change in any of the circumstances specified in §7.1606(a). Proposed new §7.1606(c) provides that an applicant or administrator may not file the §7.1606(b) notification until a proposed acquisition of control has been approved under the Insurance Code §4151.211.

§7.1607. Facts and Circumstances Affecting Issuance of Certificate of Authority. Proposed new §7.1607(a) defines the phrase *material change in fact or circumstance.* The phrase is defined as any fact or circumstance that impacts the accuracy or completeness of the information filed in an applicant's or administrator's initial application for a certificate of authority under the Insurance Code Chapter 4151. It includes: (i) a change in an applicant's or administrator's mailing address; (ii) a felony conviction of any executive officer or other comparable responsible person of an applicant or administrator or of any other person who directly or indirectly controls the applicant or administrator; and (iii) any administrative action, order, or judgment issued against an applicant or administrator. Proposed new §7.1607(b) requires an administrator to notify the Department in writing of a material change in fact or circumstance not later than the 30th day from the date the administrator first becomes aware of the material change in fact or circumstance. Except as provided by proposed new §7.1606(b) (relating to Requirements Related to Ownership Interest and Change of Control), proposed new §7.1607(c) requires an applicant to continually update the information filed in its initial application for a certificate of authority under the Insurance Code Chapter 4151 while the application is pending with the Department. This includes notifying the Department in writing of a material change in fact or circumstance. Proposed new §7.1607(d) requires an applicant or administrator to meet the requirements of the Insurance Code Chapter 4151 and the proposed new subchapter as those requirements apply to any material

change of fact or circumstance identified by an administrator or any change in information identified by an applicant. Finally, proposed new §7.1607(e) requires an applicant or an administrator to maintain the qualifications necessary to obtain a certificate of authority under Chapter 4151 at all times.

§7.1608. Fidelity Bond. Proposed new §7.1608(a) requires an applicant to obtain and an administrator to maintain a fidelity bond that complies with the requirements of the Insurance Code §4151.055 and proposed new §7.1608. Proposed new §7.1608(b) specifies that an applicant and an administrator may only obtain a fidelity bond from a surety company authorized to engage in business in this state as a surety or an eligible surplus lines insurer in compliance with the Insurance Code Chapter 981 and rules adopted thereunder. Proposed new §7.1608(c) requires an applicant or an administrator to immediately inform the Commissioner in writing if its fidelity bond is cancelled or terminated and not replaced with new coverage. The new coverage must meet the requirements of the Insurance Code §4151.055 and proposed new §7.1608 and be effective concurrently upon the date of the cancellation or termination. Finally, proposed new §7.1608(c) specifies that the required notification to the Commissioner must be given no later than ten business days from the date the applicant or the administrator first becomes aware of the cancellation or termination.

§7.1609. Annual Report. Proposed new §7.1609(a) requires an administrator to file an annual report with the Department no later than June 30 each year, accompanied by a non-refundable fee of $200. Proposed new §7.1609(b)

adopts by reference the following forms: (i) Form Number FIN 486, Annual Report Form for Administrators Holding a Certificate of Authority under TIC 4151; (ii) Form Number FIN 487, Annual Report Form for Insurers and HMOs Subject to 28 TAC §7.1605; (iii) Form Number FIN 488, Annual Report Exhibits A-E; and (iv) Form Number 490, Certification of Financial Statement. These forms are available at www.tdi.state.tx.us/forms/form5tpa.html. Proposed new §7.1609(c) specifies that the annual report required by proposed new §7.1609(a) must also include an audit report on the financial statements prepared by an independent certified public accountant that reflects an audit conducted in accordance with generally accepted auditing standards or with the standards adopted by the Public Company Accounting Oversight Board, as applicable. It must also include a balance sheet, an income statement, a cash flow statement, and a statement of equity. Proposed new §7.1609(d)(1) exempts an administrator receiving less than $10 million in compensation for providing administrative services in Texas during the preceding year from complying with the requirements of proposed new §7.1609(c) for that year. Proposed new §7.1609(d)(2) requires an administrator qualifying for the exemption in §7.1609(d)(1) to file a financial statement with the Department that: (i) includes a completed Form Number FIN 490, Certification of Financial Statement, as referenced in §7.1609(b)(1)(D); and (ii) is verified by at least two officers or other comparable responsible persons of the administrator. Proposed new §7.1609(d)(3) clarifies that an administrator qualifying for the exemption in proposed new §7.1609(d)(1) must still meet the

other requirements of proposed new §7.1609. Proposed new §7.1609(e) provides that the Commissioner may request additional information as necessary to determine if an administrator is operating or conducting business in a hazardous or injurious manner.

§7.1610. Financial Statements Under the Education Code. Proposed new §7.1610(a) provides that §7.1610 applies only to an insurer or HMO that: (i) meets the requirements of §7.1605 (relating to Notification Requirements) of this subchapter; and (ii) is subject to the requirements of the Education Code §22.004(g). Proposed new §7.1610(b) provides that an administrator meeting the requirements of §7.1610(a) may comply with the requirement for an audited financial statement under the Education Code §22.004(h) by providing a copy of the financial statement filed with the Department for the preceding calendar year that: (i) was prepared by an independent certified public accountant and; (ii) was filed in compliance with the requirements of §7.18 (relating to the National Association of Insurance Commissioners Accounting Practices and Procedures Manual) and §7.85 (relating to Audited Financial Reports).

§7.1611. Operational Review and On-Site Audit. Proposed new §7.1611(a) requires an insurer, no less than two times each fiscal year, to review the operations of each of its administrators that, in the aggregate, administers benefits in Texas on behalf of the insurer for more than 100 certificate holders, injured employees, plan participants, or policyholders. Proposed new §7.1611(a) also provides that a review of an administrator may be conducted on the

premises of the insurer or at another location designated by the insurer. The review may also be conducted by electronic means. Proposed new §7.1611(b) requires an insurer, no less than once every two fiscal years, to conduct an on-site audit of each of its administrators that, in the aggregate, administers benefits in Texas on behalf of the insurer for more than 100 certificate holders, injured employees, plan participants, or policyholders. Proposed new §7.1611(c) specifies that, notwithstanding the requirements of proposed new §7.1611(a), an insurer is not required to review the operations of an administrator under proposed new §7.1611(a) more than one time in the same fiscal year in which the insurer conducts an on-site audit of that administrator. Proposed new §7.1611(d) specifies that any review and on-site audit must assess the business practices and procedures of the administrator to ensure competent administration, including evaluating: (i) the administrator's compliance with the Insurance Code, the Labor Code, and rules adopted thereunder, as applicable; (ii) the administrator's compliance with the provisions of the written agreement with the insurer; (iii) the administrator's performance of claims adjudication and payment; (iv) the adequacy of the financial security maintained by the administrator, if any; and (v) the administrator's practices and procedures for establishing the adequacy of the insurer's reserves, if any. Proposed new §7.1611(d) also specifies that any review and on-site audit must include a written summary of the objectives and scope of the review or on-site audit and the results of the review or on-site audit. It must also include a corrective action plan

addressing any deficiencies found during the review or on-site audit. Proposed new §7.1611(e) specifies that the purpose of the on-site audit is to verify the accuracy, integrity, and completeness of the information received during a review conducted by an insurer pursuant to proposed new §7.1611(a). Proposed new §7.1611(e) also requires that an on-site audit include: (i) a physical inspection of the administrator's place of business; and (ii) a written assessment of the reliability of the information provided to the insurer and relied upon by the insurer when conducting a review or on-site audit of the administrator. Proposed new §7.1611(f) authorizes an insurer or the insurer's designated representative to perform a review or an on-site audit. Proposed new §7.1611(g) permits an insurer to meet the requirements of proposed new §7.1611 for an administrator subcontractor by reviewing and auditing only the administrator contractor if two specified conditions are met: (i) the information supplied to the insurer by the administrator contractor includes all necessary and relevant information relating to the administrator subcontractor; and (ii) provided no evidence of material non-compliance by the administrator subcontractor exists. Proposed new §7.1611(h) requires all information and documentation related to a review or an on-site audit to remain on file with the insurer for at least five years from the date of the review or on-site audit and to be made available to the Commissioner upon request.

§7.1612. Fiduciary Bank Accounts. Pursuant to the Insurance Code §4151.106(b), proposed new §7.1612(a) requires an administrator to hold all premium in a fiduciary capacity. Proposed new §7.1612(b) requires an

administrator collecting or receiving any premium to comply with the Insurance Code §4151.105, §4151.106, §4151.107, and §4151.108 and proposed new rule §7.1612. Proposed new §7.1612(b) also requires each administrator who receives any premium on behalf of an insurer, HMO, plan sponsor, or group to report the receipt of that premium to the insurer, HMO, plan sponsor, or group within a reasonable amount of time. Proposed new §7.1612(c) requires an administrator to establish at least one fiduciary bank account to hold any premium collected or received pursuant to proposed new §7.1612. Proposed new §7.1612(d) requires a fiduciary bank account required by proposed new §7.1612(c) to be established and styled as an escrow account. Proposed new §7.1612(e) requires an administrator to maintain each fiduciary bank account at a financial institution that is (i) organized under the laws of the United States or any state thereof, and (ii) regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies. Additionally, proposed new §7.1612(e) specifies that a fiduciary bank account may only consist of one or more of the following types of investments: (i) cash and cash equivalents, including savings accounts, checking accounts, money market accounts, and certificates of deposit; (ii) non-assessable money market mutual funds that are primarily invested in United States government securities; and (iii) other investments of substantially similar quality, as approved by the Commissioner. Proposed new §7.1612(f) requires an administrator to maintain detailed accounting records for each fiduciary bank

account that separately record each deposit and withdrawal from the account. The accounting records must identify each insurer, HMO, plan sponsor, or group for whom the account is maintained. Proposed new §7.1612(g) requires that, upon the reasonable request of the insurer, HMO, plan sponsor, or group, an administrator must provide an insurer, HMO, plan sponsor, or group a copy of all records relating to the requesting entity's account activity in a fiduciary bank account established or maintained by the administrator on behalf of the insurer, HMO, plan sponsor, or group. Proposed new §7.1612(h) provides that all records maintained by an administrator relating to any premium shall be subject to examination by the Commissioner upon request. Pursuant to the Insurance Code §4151.109, proposed new §7.1612(i) prohibits an administrator from paying a claim from a fiduciary bank account. Finally, proposed new §7.1612(j) provides that proposed new §7.1612 does not authorize any transaction that is otherwise prohibited by law.

§7.1613. Written Agreements Between Administrators and Insurers. Proposed new §7.1613(a) prohibits an administrator from providing administrative services in Texas on behalf of an insurer unless the administrator has entered into a written agreement with the insurer that meets the requirements of the Insurance Code Chapter 4151 and proposed new §7.1613. Proposed new §7.1613(b) permits an administrator subcontractor to meet the requirements of proposed new §7.1613 by entering into a written agreement with the administrator contractor only. Section 7.1613(b) also requires that the written

agreement meet the requirements of the Insurance Code Chapter 4151 and proposed new §7.1613, as applicable. Proposed new §7.1613(c) prohibits a written agreement entered into under proposed new §7.1613 from being construed to limit, in any way, an insurer's ultimate accountability and responsibility for compliance with all statutory and regulatory requirements under the Insurance Code, the Labor Code, and rules adopted thereunder. Proposed new §7.1613(d) requires a written agreement entered into under proposed new §7.1613 to include: (i) a requirement that an administrator comply with the requirements of the Insurance Code, the Labor Code, and rules adopted thereunder, including holding appropriate authorizations; (ii) a description of the administrative services the administrator is expected to provide and any applicable instructions related to the performance of those services, including references to an insurer's claims handling practices or procedures; (iii) a provision relating to the continuity of services and addressing the obligations of the administrator and the insurer under proposed new §7.1615 (relating to Transfer of Books and Records), including the method and manner in which the insurer and administrator will meet those requirements; and (iv) a provision addressing an insurer's obligation to review and audit the performance of its administrators under proposed new §7.1611 (relating to Operational Review and On-Site Audit), including the method and manner in which the insurer will meet those requirements. Proposed new §7.1613(e) also requires a written agreement entered into under proposed new §7.1613 to ensure that the books

and records of the insurer remain the property of the insurer at all times and that the books and records of the insurer are available to the insurer or its designee at any time while in the custody of the administrator. Proposed new §7.1613(f), however, permits an administrator to retain a proprietary interest in the books and records of an insurer pursuant to the Insurance Code §4151.113(c) under one condition. Retention of a proprietary interest requires that the written agreement between the administrator and the insurer must specifically identify the items that will be subject to the administrator's proprietary interest. Further, proposed new §7.1613(f) prohibits an administrator from withholding, based upon a claim of proprietary interest, any portion of an insurer's books and records that would restrict the ability of the insurer to comply with statutory, regulatory, or contractual obligations. Proposed new §7.1613(g) permits a master services agreement to be used to meet the §7.1613 requirements. Proposed new §7.1613(h) permits any §7.1613 requirement that does not apply to an administrative service offered or performed by the administrator on behalf of the insurer to be omitted from the written agreement between the administrator and the insurer. Proposed new §7.1613(h) also requires the remainder of the written agreement between the administrator and the insurer to comply with the Insurance Code Chapter 4151 and proposed new §7.1613. Finally, proposed new §7.1613(i) requires a written agreement to meet the requirements of proposed new §7.1613 no later than September 1, 2009.

§7.1614. Prohibited Acts. Proposed new §7.1614(a) prohibits an administrator from: (i) misrepresenting the terms or nature of an agreement with an insurer, HMO, plan sponsor, or group; (ii) making false, misleading, or incomplete comparisons to the agreements of other administrators or persons in order to induce any person to enter into, continue, or discontinue an agreement; (iii) accepting or rejecting risk, other than under the authority of, and in accordance with, a written agreement with an insurer, HMO, plan sponsor, or group; (iv) publishing or circulating any advertising or informational material, benefit descriptions, certificates, booklets, or brochures pertaining to business underwritten by an insurer, HMO, plan sponsor, or group without advance written approval of the insurer, HMO, plan sponsor, or group; (v) pursuant to the Labor Code §415.0036, offering to pay, paying, soliciting, or receiving an improper inducement relating to the delivery of benefits to an injured employee, if the administrator performs administrative services on behalf of a person who is a participant in the workers' compensation system of this state; and (vi) pursuant to the Labor Code §415.0036, improperly attempting to influence the delivery of benefits to an injured employee, including through the making of improper threats, if the administrator performs administrative services on behalf of a person who is a participant in the workers' compensation system of this state. Proposed new §7.1614(b) provides that an administrator may be subject to other prohibitions under the Insurance Code, the Labor Code, and rules adopted thereunder that are not specified in proposed new §7.1614(a).

§7.1615. Transfer of Books and Records. Proposed new §7.1615(a) requires an administrator to provide books and records to a successor administrator no later than 30 days from the date of the termination of the relationship or written agreement with an insurer, HMO, plan sponsor, or group, unless otherwise provided by the Commissioner. If there is not a successor administrator, or if the successor administrator is unknown at the time of the required transfer, the set or copy of the books and records must be provided to the insurer, HMO, plan sponsor, or group. The books and records must be provided either as a complete and accurate original set or a complete and accurate copy or image of the original set of an insurer's, HMO's, plan sponsor's, or group's books and records. to a successor administrator. Proposed new §7.1615(b) requires the books and records to be transferred in an organized and usable manner. Proposed new §7.1615(c) requires the allocation of the payment of costs associated with providing the insurer's books and records to be addressed in the written agreement between the insurer and the administrator. Proposed new §7.1615(d) requires an administrator to provide written notice to the Department of the termination of a relationship or written agreement with an insurer, HMO, plan sponsor, or group no later than thirty days from the date the administrator first learns of the termination. Proposed new §7.1615(e) permits an administrator subcontractor to meet the requirements of proposed new §7.1615 when its relationship or written agreement with an administrator contractor terminates by providing a complete and accurate original set or a complete and accurate copy

or image of the original set of the insurer's, HMO's, plan sponsor's, or group's books and records to the administrator contractor. The administrator subcontractor must also provide written notice to the Department of the termination of the relationship or written agreement with the administrator contractor no later than thirty days from the date the administrator subcontractor first learns of the termination.

§7.1616. Hazardous or Injurious Operating Conditions. Proposed new §7.1616(a) provides that an applicant or an administrator may be considered to be operating or conducting business in a hazardous or injurious manner if the administrator or applicant: (i) has failed to file financial statements, documents, records, or reports required under the Insurance Code Chapter 4151 or the proposed new subchapter within the time periods prescribed by the Insurance Code Chapter 4151, the proposed new subchapter, or as requested by the Department pursuant to law; (ii) has filed any false or misleading financial information; (iii) is unable to pay its obligations as they become due and payable; (iv) has not maintained records sufficient to permit examiners to determine its financial condition or compliance with the Insurance Code, the Labor Code, and rules adopted thereunder; (v) does not employ management staff with the experience, competence, or trustworthiness to conduct its operations in a safe or sound manner; (vi) employs management staff that has engaged in any unlawful activity; (vii) has not complied or is not complying with the terms of a written agreement with an insurer, HMO, plan sponsor, or group;

(viii) has engaged or is engaging in a pattern of failing to settle claims in accordance with contractual, regulatory, or statutory requirements; or (ix) has engaged or is engaging in fraudulent or dishonest practices or acts. Proposed new §7.1616(b) provides that other facts and circumstances not specified in proposed new §7.1616(a) may also indicate that an applicant or administrator is operating in a hazardous or injurious manner.

§7.1617. Examinations. New §7.1617(a) proposes the adoption of a non-refundable fee of $500 for the expenses of an examination conducted under the Insurance Code §4151.201. Proposed new §7.1617(b) provides that, prior to an examiner entering the property of an administrator, written notice must be given to the administrator. The written notice must include the date and estimated time the examiner will enter the property of the administrator.

§7.1618. Severability. Proposed new §7.1618 provides that if any section or portion of a section of the proposed new subchapter is held to be invalid for any reason, all valid parts are severable from the invalid parts and remain in effect. Further, proposed new §7.1618 provides that if any section or portion of a section of the proposed new subchapter is held to be invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications. Finally, proposed new §7.1618 provides that all provisions of the proposed new subchapter are severable.

2. FISCAL NOTE. Danny Saenz, Senior Associate Commissioner for the Financial Program, has determined that for each year of the first five years the proposed new sections will be in effect, there may be an approximate $87,250 - $88,750 total annual increase in revenue to state government as a result of the enforcement and administration of this proposal due to estimated additional applications for a certificate of authority, estimated additional annual report submissions, estimated additional examinations of administrators, and estimated additional fingerprint submissions to the DPS. These estimates are based on the following factors.

First, the proposed new sections do not impose new application filing fees on administrators holding current authorizations from the Department. However, the proposed new sections impose a new $1,000 application filing fee on each person applying for a new authorization from the Department under the Insurance Code Chapter 4151. The Department anticipates that it will receive 50 new applications for a certificate of authority under the Insurance Code Chapter 4151 annually, resulting in an approximate $50,000 total annual increase in revenue to state government.

Second, the proposed new sections impose a new $200 filing fee on each person submitting an annual report to the Department pursuant to the Insurance Code §4151.205. Each person holding an authorization from the Department under the Insurance Code Chapter 4151 is required to file an annual report with the Department. As previously indicated, the Department estimates that it will

receive 50 new applications for a certificate of authority under the Insurance Code Chapter 4151 annually. If the Department approves each of these applications, the Department estimates that it will receive 50 additional annual report filings from these new administrators, resulting in an approximate $10,000 total annual increase in revenue to state government.

Third, the proposed new sections impose a new $500 filing fee on each administrator that is examined by the Commissioner pursuant to the Insurance Code §4151.201. As previously indicated, the Department estimates that it will receive 50 new applications for a certificate of authority under the Insurance Code Chapter 4151 annually. If the Department approves each of these applications and examines each of these new administrators, there will be an approximate $25,000 total annual increase in revenue to state government.

Finally, the proposed amendments do not impose new fingerprinting costs on the executive officers or other comparable responsible persons of an administrator holding a current authorization from the Department. As a result, the Department generally does not anticipate that any executive officer or other comparable responsible person of an administrator holding an authorization under the Insurance Code Chapter 4151 on the effective date of the proposed new sections will be required to submit fingerprints to the DPS. This is applicable so long as the information submitted by the administrator with regard to its key management or decision making personnel at the time of application remains unchanged. However, the proposed new sections impose new fingerprinting

fees on each executive officer or other comparable responsible person of an applicant applying for a new authorization from the Department under the Insurance Code Chapter 4151 and on any individual that has the right to control, direct, or manage the affairs of an applicant for a certificate of authority under the Insurance Code Chapter 4151. Of the 50 new applications for a certificate of authority that are anticipated, the Department anticipates that between 3 and 5 individuals per applicant will be required to submit fingerprints to the DPS under the proposed new sections. This results in an estimated total of 150 – 250 new fingerprint submissions annually. The Government Code §411.088(a)(2) authorizes the DPS to charge a $15 fee for each criminal history record information inquiry. Therefore, this may result in a $2,250 - $3,750 total annual increase in revenue to state government. However, it is the Department's understanding based on information provided by the DPS that this fee is for the costs of processing fingerprints and maintaining the records and systems used by the DPS in processing fingerprint submissions. Therefore, anticipated additional fingerprint submissions may result in increased costs to the DPS, which may substantially offset or eliminate any additional revenue. Further, it is anticipated that most individuals within Texas will utilize the convenience and reliability offered by the authorized electronic fingerprint services. The Department, therefore, estimates that there will be no measurable fiscal impact to local governments from the capture of fingerprints on paper cards by local law

enforcement agencies as a result of the enforcement or administration of this proposal.

There will be no anticipated effect on local employment or the local economy as a result of the proposal.

3. PUBLIC BENEFIT/COST NOTE. Mr. Saenz has also determined that for each year of the first five years the proposed new sections are in effect, there are several anticipated public benefits, and there will be potential costs for persons required to comply with the proposal.

Anticipated Public Benefits. The anticipated public benefits include: (i) a more efficient and standardized process for regulating administrators, resulting in ease of operations and processes for the industry and the Department; (ii) increased oversight of administrators, resulting in increased accountability for compliance with the Insurance Code, the Labor Code, and rules adopted thereunder; and (iii) more efficient regulation of the industry by ensuring that persons receiving authorizations from the Department are honest, trustworthy, reliable, and fit to hold those authorizations.

The proposal streamlines the application process for applicants and clarifies certain requirements for applicants and administrators. It is anticipated that this will result in more efficient regulation of the industry and increased compliance with Department rules. Additionally, the proposal specifies the scope and applicability of the proposed new rules. First, the proposal provides

necessary guidance to applicants and administrators regarding the applicability of the proposed new rules. HB 472 requires persons providing administrative services in connection with workers' compensation benefits in this state to comply with the requirements of the Insurance Code Chapter 4151. Prior to the enactment of HB 472, these persons were not subject to the requirements of Chapter 4151. As a result, many persons may be unfamiliar with the processes, procedures, and requirements of Chapter 4151 and the implementing rules. Providing additional guidance to these persons should increase their compliance with the requirements of the proposed new rules and should result in more efficient regulation. The proposal also clarifies the requirements of Chapter 4151 for persons holding other authorizations issued under the Insurance Code or the Labor Code. This clarification is particularly significant because a person may be simultaneously subject to the requirements of different provisions of the Insurance Code, the Labor Code, or rules adopted thereunder based upon the diversity of the functions performed by that person. In such situations, a person may be required to hold one or more authorizations issued under the Insurance Code or the Labor Code in order to perform those regulated functions. By providing additional guidance to applicants and administrators regarding their obligations under Chapter 4151, it is anticipated that a greater number of applicants and administrators will comply with the requirements of the Insurance Code, the Labor Code, and rules adopted thereunder. This should result in more efficient and consistent regulation of the industry.

The proposal also requires increased oversight of all administrators, which should result in increased accountability for compliance with the requirements of the Insurance Code, the Labor Code, and rules adopted thereunder. First, the proposal requires applicants and administrators to report (i) changes in the control of their organizations and (ii) changes affecting their compliance with Chapter 4151 and the proposed new rules. By requiring applicants and administrators to timely report these changes to the Department, the Department is better able to ensure that the reported changes will not adversely affect the ability of the applicant or administrator to comply with the requirements of Chapter 4151. The Department will also be able to ensure that the reported changes are in the best interest of the public and the insurance consumers of this state. Further, the proposal requires administrators to submit annual reports to the Department. This proposed requirement will enable the Department to better monitor the financial health of each administrator. It will also allow the Department to monitor each administrator's compliance with applicable statutory and regulatory requirements, such as timely claims payment and proper remittance of collected premiums. Additionally, because administrators often perform a wide variety of administrative duties on behalf of insurers, the proposal requires insurers to review and audit the performance of their administrators. This proposed requirement will assist in ensuring that administrators perform their delegated administrative functions in accordance with the requirements of the Insurance Code, the Labor Code, and rules adopted thereunder. This is

particularly important because an insurer retains ultimate responsibility and accountability for each function performed by an administrator. By requiring each insurer to properly oversee the performance of its administrators, an insurer should obtain a better idea of its own capabilities, strengths, and weaknesses, as well as any deficiencies in statutory or regulatory compliance. This should result in financially healthier and more compliant insurers. Further, requiring each insurer to properly oversee its administrators' performance, compliance with applicable statutes and rules, and overall health and integrity should result in financially healthier and more productive, efficient, and compliant administrators.

Finally, the proposal requires certain individuals to submit biographical affidavits and complete sets of fingerprints to the Department upon application for a certificate of authority. It is, therefore, anticipated that only those persons that are honest, trustworthy, reliable, and fit to hold a certificate of authority from the Department will be granted such authorization. This proposed requirement will assist in ensuring the safety of the public and the integrity of the persons holding authorizations from the Department.

Potential Costs for Persons Required to Comply with the Proposal.

Under the Insurance Code Chapter 4151 and the proposed new rules, a person may act as or hold itself out as an administrator. No person is required by law to act as or hold itself out as an administrator. However, for those persons that choose to act as or hold themselves out as an administrator, the

proposal prescribes requirements for both applicants and administrators holding a certificate of authority under Chapter 4151.

Proposed New §7.1606, §7.1607, and §7.1608 Requirements for Applicants for a Certificate of Authority and Persons Holding a Certificate of Authority. There will be costs of compliance with proposed new §7.1606, §7.1607, and §7.1608, both for applicants and for persons that currently hold a certificate of authority from the Department under Chapter 4151. These requirements apply to persons at the time of application, to persons newly receiving a certificate of authority, and to persons currently holding a certificate of authority. The Department anticipates that the types of costs of compliance with these proposed requirements will generally be the same for persons holding a current certificate of authority under Chapter 4151 as for applicants applying for and newly receiving a certificate of authority under Chapter 4151. These anticipated costs of compliance are as follows.

The probable costs associated with proposed new §7.1606, §7.1607, and §7.1608 result from: (i) notification requirements for a change in control of ownership; (ii) notification requirements related to a material change in fact or circumstance that impacts the accuracy or completeness of the information filed in an applicant's or administrator's initial application for a certificate of authority; and (iii) fidelity bond requirements.

Proposed new §7.1606 prescribes notification requirements for applicants and administrators involved in a change of control of ownership. The

requirements of proposed new §7.1606 only apply to applicants and administrators that experience a change of control of ownership. If there is no change of control, there will be no costs of compliance with §7.1606 for an applicant or administrator. The anticipated costs of compliance are related to the requirement in proposed new §7.1606(b) that an applicant or administrator must notify the Department in writing of a change of control in the ownership of the applicant or administrator. This notification must be submitted not later than the 30th day after the effective date of the change. The Department anticipates that the total probable cost of preparing and submitting the information required under proposed new §7.1606(b) will be less than $60. This is based upon a member of an applicant's or administrator's administrative staff preparing the necessary information in less than one hour. The salary for this staffer is estimated at the mean salary rate of $14.13 per hour, as set forth for similar office and administrative support positions in the May 2007 State Occupational Employment and Wage Estimates for Texas published by the U.S. Department of Labor at http://www.bls.gov/oes/current/oes_tx.htm. This publication will hereafter be referred to in this Cost Note as the DOL May 2007 Texas Wage Estimates. The provided link is also applicable to all subsequent references. Additionally, the Department estimates that a member of an applicant's or administrator's management staff could review and approve the prepared information in less than one hour. The salary for this staffer is estimated at the mean salary rate of

$44.87 per hour, as set forth for similar management positions in the DOL May 2007 Texas Wage Estimates.

Proposed new §7.1607 prescribes notification requirements related to a material change in fact or circumstance that impacts the accuracy or completeness of the information filed in an applicant or administrator's initial application for a certificate of authority under Chapter 4151. Proposed new §7.1607(b) requires an administrator to notify the Department of a material change in fact or circumstance not later than the 30th day from the date the administrator first becomes aware of the material change in fact or circumstance. Proposed new §7.1607(c) requires an applicant to continually update the information filed in its initial application for a certificate of authority, including notifying the Department in writing of a material change in fact or circumstance, while the application is pending with the Department. The requirements of proposed new §7.1607(b) only apply to administrators that experience a change in fact or circumstance that impacts the accuracy or completeness of the information filed in the administrator's initial application for a certificate of authority under Chapter 4151. If there is no such change in fact or circumstance, there will be no costs for compliance with §7.1607(b). The Department estimates that the total probable costs for complying with proposed new §7.1606(b) should be less than $60. This is based upon a member of an administrator's administrative staff preparing the necessary information in less than one hour. The salary for this staffer is estimated at the mean salary rate of $14.13 per hour,

as set forth for similar office and administrative support positions in the DOL May 2007 Texas Wage Estimates. Additionally, the Department estimates that a member of an administrator's management staff could review and approve the prepared information in less than one hour. The salary for this staffer is estimated at the mean salary rate of $44.87 per hour, as set forth for similar management positions in the DOL May 2007 Texas Wage Estimates. The Department anticipates that the total probable cost to comply with proposed new §7.1607(b) will vary substantially among administrators depending upon how often a particular administrator experiences a material change in fact or circumstance that warrants notification to the Department. For example, if an administrator changes its mailing address, has a judgment issued against it, and learns that one of its executive officers is convicted of a felony, that particular administrator may incur higher compliance costs than an administrator that experiences fewer material changes. Proposed new §7.1607(c) requires an applicant to continually update the information filed in its initial application for a certificate of authority. This includes notifying the Department in writing of a material change in fact or circumstance, while the application is pending with the Department. If an applicant does not experience such a change, there will be no costs of compliance with proposed new §7.1607(c) for the applicant. The Department anticipates that the total probable costs associated with complying with proposed new §7.1606(c) should be less than $60. This is based upon a member of an applicant’s administrative staff preparing the necessary

information in less than one hour. The salary for the staffer is estimated at the mean salary rate of $14.13 per hour, as set forth for similar office and administrative support positions in the DOL May 2007 Texas Wage Estimates. Additionally, the Department estimates that a member of an applicant's management staff could review and approve the prepared information in less than one hour. The salary for the staffer is estimated at the mean salary rate of $44.87 per hour, as set forth for similar management positions in the DOL May 2007 Texas Wage Estimates. The Department anticipates that the total probable compliance cost will vary substantially among applicants. The actual total costs will depend upon how often a particular applicant experiences a change in the information filed in its initial application while its application is pending with the Department. For example, if an applicant changes its mailing address or replaces one of its executive officers while its application is pending with the Department, that particular applicant may incur higher compliance costs than an applicant that experiences no such changes. Proposed new §7.1607(e) requires an applicant or administrator to maintain the qualifications necessary to obtain a certificate of authority under Chapter 4151 at all times. The total probable costs of compliance with proposed new §7.1606(e) will depend upon several factors, including: (i) how often an applicant experiences a change in the information filed in its initial application for a certificate of authority, including a material change in fact or circumstance; while its application is pending with the Department; (ii) how often an administrator experiences a material change of

fact or circumstance that affects its manner of compliance with the requirements of Chapter 4151 and the proposed new rules; and (iii) how often an applicant or administrator chooses to change a factor affecting its manner of compliance with the requirements of Chapter 4151 and the proposed new rules. For example, if a person acquires a new ownership interest in an applicant or administrator, the person may incur additional costs in order to meet the requirements of Chapter 4151 and the proposed new rules related to that specific change. This could include: (i) applicable fingerprint and biographical affidavit requirements under proposed new §7.1604 (relating to Application for Certificate of Authority); (ii) notification requirements under proposed new §7.1606 (relating to Requirements Related to Ownership Interest and Change of Control); and (iii) notification requirements under proposed new §7.1607 (relating to Facts and Circumstances Affecting Issuance of Certificate of Authority). However, an applicant or administrator that does not experience such changes will not incur any compliance costs under proposed new §7.1606(e).

Proposed new §7.1608 prescribes requirements related to applicant and administrator fidelity bonds. First, proposed new §7.1608(a) requires an applicant to obtain, and an administrator to maintain, a fidelity bond that complies with the requirements of the Insurance Code §4151.055 and the proposed new rules. Proposed new §7.1608(b) requires applicants and administrators to obtain their fidelity bonds from a surety company authorized to engage in business in this state as a surety or an eligible surplus lines insurer in compliance with the

Insurance Code Chapter 981 and rules adopted thereunder. Based upon the information available to the Department, the Department anticipates that the cost of a fidelity bond for an applicant or administrator meeting the requirements of proposed new §7.1608 should be between $150 - $550 per applicant or administrator. The actual cost to each applicant or administrator will depend on factors unique to each applicant or administrator, such as: (i) the structure of the applicant's or administrator's business organization; (ii) the applicant's or administrator's past claims history; and (iii) the size and complexity of the applicant or administrator. The Department, however, anticipates that all such costs will be passed on in the form of administrative fees. As a result, the total actual compliance costs should be significantly minimized. Proposed new §7.1608(c) requires an applicant or administrator to notify the Commissioner in writing if its fidelity bond is cancelled or terminated under certain specified circumstances. The written notice is required if the cancelled or terminated fidelity bond is not replaced with new coverage (i) that meets the requirements of the Insurance Code §4151.055 and the proposed new rules and (ii) that is effective concurrently upon the date of the cancellation or termination. The Department anticipates that the total probable costs for complying with proposed new §7.1608(c) should be less than $60. This is based upon a member of an applicant's or administrator's administrative staff preparing the necessary information in less than one hour. The salary for the staffer is estimated at the mean salary rate of $14.13 per hour, as set forth for similar office support and

administrative positions in the DOL May 2007 Texas Wage Estimates. Additionally, the Department anticipates that a member of an applicant's or administrator's management staff could review and approve the prepared information in less than one hour. The salary for the staffer is estimated at the mean salary rate of $44.87 per hour, as set forth for similar management positions in the DOL May 2007 Texas Wage Estimates.

Each applicant or administrator has the information necessary to estimate its own compliance costs with proposed new §7.1606, §7.1607, and §7.1608. Any other costs to comply with these proposed new rules result from the legislative enactment of Chapter 4151 and are not a result of the adoption, enforcement, or administration of the proposal.

Proposed New §7.1604 and §7.1605 Requirements for Applicants for a Certificate of Authority. The proposal prescribes additional requirements for applicants applying for a certificate of authority under Chapter 4151. In addition to the costs of compliance with the requirements in §7.1606, §7.1607, and §7.1608, there will be costs for compliance with the requirements in proposed new §7.1604 and §7.1605 for such applicants. Proposed new §7.1604 prescribes requirements for a certificate of authority under Chapter 4151. Proposed new §7.1604(a) requires an applicant who seeks a certificate of authority under Chapter 4151 to file an application with the Department. This must be accompanied by a non-refundable fee of $1,000. Proposed new §7.1604(a) also requires the applicant to verify the application by attesting to the

truth and accuracy of the information in the application. Proposed new §7.1604(b) adopts four forms by reference that comprise the application for a certificate of authority under Chapter 4151. Proposed new §7.1604(c) requires an applicant to register its official name with the Department and the Office of the Secretary of State, as applicable. Further, if the Commissioner determines that an applicant's name is too similar to a name already registered with the Department, proposed new §7.1604(c) requires the applicant to register an alternative name with the Department and the Office of the Secretary of State, as applicable. Proposed new §7.1604(d)(1) requires each executive officer or other comparable responsible person of an applicant to provide the Department a completed biographical affidavit. Proposed new §7.1604(d)(2) requires each person filing a biographical affidavit to comply with the requirements of Chapter 1, Subchapter D of Title 28 of the Texas Administrative Code (relating to Effect of Criminal Conduct). The Department anticipates that the total probable costs for complying with the §7.1604 identification, notification, and documentation requirements will be less than $2,300. This estimate is based upon the following factors. First, an applicant must submit a non-refundable $1,000 filing fee to the Department with its application for a certificate of authority. Second, the Department anticipates that a member of an applicant's administrative staff could prepare the information necessary to comply with the identification, notification, and documentation requirements of proposed new §7.1604 in less than eight hours. The salary for this staffer is estimated at the mean salary rate of $14.13

per hour, as set forth, as set forth for similar office support and administrative positions in the DOL May 2007 Texas Wage Estimates. Additionally, the Department anticipates that a member of an applicant's management staff could review and approve the prepared information in less than five hours. The salary for this staffer is estimated at the mean salary rate of $44.87 per hour, as set forth for similar management positions in the DOL May 2007 Texas Wage Estimates. Proposed new §7.1604(c) requires each applicant to register its official name with the Office of the Secretary of State, as applicable. Based upon information available to the Department, the Department estimates that a domestic applicant will be required to submit a $300 filing fee to the Office of the Secretary of State and that a foreign applicant will be required to submit a $750 filing fee to the Office of the Secretary of State. Proposed new §7.1604(d)(2) requires each executive officer or other comparable responsible person of an applicant to comply with the fingerprint requirements of Chapter 1, Subchapter D of Title 28 of the Texas Administrative Code (relating to Effect of Criminal Conduct. This requires the submission of a complete set of fingerprints and certain identifying information. The Department estimates that the probable costs of complying with the fingerprint requirements should be $45 - $55. The Department has been informed by the FBI and DPS that each individual who must provide fingerprints under 28TAC§1.503(2) must pay a fingerprinting fee of $34.25. The $34.25 fingerprinting processing fee includes an FBI charge of $19.25 and a DPS charge of $15. Additionally, there is a $9.95 fingerprint

collection fee charged by companies that take electronic fingerprints on behalf of the Department. While the Department anticipates that most individuals in the State of Texas will utilize the convenience and reliability offered by authorized electronic fingerprint services, an individual may choose to submit a paper fingerprint card instead of an electronic fingerprint submission. In those cases, the individual must submit payment in the amount of $44.20 payable to the DPS, which includes the fingerprinting processing fee of $34.25 and the fingerprint collection fee of $9.95. Additionally, an individual may have his or her fingerprints captured on a paper fingerprint card by a criminal law enforcement agency. The Human Resources Code §80.001(b) authorizes a charge for such service in an amount not to exceed $10. Lastly, any additional information that must be supplied by an individual at the time of fingerprinting is minimal. Therefore, the Department does not anticipate any cost for providing such required information. Further, the Department anticipates that an individual or applicant should only have to submit a complete set of fingerprints under the proposal one time. This is based on the applicant maintaining continuous licensure with the Department.

Proposed new §7.1605 prescribes notification requirements for certain qualifying insurers or HMOs that choose to act as or hold themselves out as administrators. Proposed new §7.1605(b) requires a qualifying insurer or HMO to submit written notice to the Department stating that it will be acting as or holding itself out as an administrator. Proposed new §7.1605(b) also requires

the written notice to include (i) the insurer's or HMO's contact information, (ii) a narrative, and (iii) a list of any other states in which the insurer or HMO will be acting as or holding itself out as an administrator. The Department anticipates that the total probable cost of preparing and submitting the information required under proposed new §7.1605(b) will be less than $60. This is based upon a member of an insurer's or HMO's administrative staff preparing the information necessary to comply with proposed new §7.1605 in less than one hour. The salary for the staffer is estimated at the mean salary rate of $14.13 per hour, as set forth for similar office support and administrative positions in the DOL May 2007 Texas Wage Estimates. Additionally, the Department estimates that a member of an insurer's or HMO's management staff could review and approve the information prepared by a member of the insurer's or HMO's administrative staff in less than one hour. The salary for the staffer is estimated at the mean salary rate of $44.87 per hour, as set forth for similar management positions in the DOL May 2007 Texas Wage Estimates.

Any other costs to comply with proposed new §7.1604 and §7.1605 result from the legislative enactment of Chapter 4151 and are not a result of the adoption, enforcement, or administration of the proposal.

Proposed New §7.1609, §7.1612, §7.1613, §7.1615, and §7.1617 Requirements for Administrators. There will be costs of compliance with proposed new §7.1606, §7.1612, §7.1613, §7.1615, and §7.1617 for persons that hold a certificate of authority as an administrator under Chapter 4151.

These costs will be incurred by persons upon receiving a certificate of authority under Chapter 4151. Such costs will also be incurred by persons currently holding a certificate of authority under Chapter 4151.

Proposed new §7.1609 prescribes requirements related to an administrator's annual report filing. First, proposed new §7.1609(a) requires an administrator to file an annual report with the Department each year. It must be accompanied by a non-refundable fee of $200. Proposed new §7.1609(b) adopts the Annual Report Forms, Annual Report Exhibits, and Certification Form by reference. Proposed new §7.1609(c) requires each annual report to include an audit report on the financial statements prepared by an independent certified public accountant (CPA) that meets certain specified requirements, unless an administrator is exempt from this requirement under proposed new §7.1609(d)(1). Proposed new §7.1609(d)(2) permits an administrator earning less than $10 million in compensation for providing administrative services in Texas to file a financial statement with the Department as part of its annual report in lieu of filing the audit report required by §7.1609(c). Proposed new §7.1609(d)(3) requires each administrator qualifying for the exemption in §7.1609(d)(1) to meet all the other requirements of §7.1609. The preparation and compilation costs associated with submitting an annual report filing will vary among administrators depending upon the amount and quality of data routinely collected and maintained by the administrator. An annual report generally requires the submission of a minimal amount of information relating to the

services performed by a particular administrator. This includes information such as the administrator's claims data or the amount of premium collected by the administrator on behalf of a particular insurer. The Department expects the majority of administrators to retain this type of information on a regular basis in order to appropriately perform their delegated duties and to satisfy their own business needs, such as filing federal income taxes. As a result, the Department anticipates that a member of an applicant's or administrator's management staff could compile, review, and approve the information necessary to comply with proposed new §7.1609 in 12 – 24 hours. The Department also anticipates that this estimated range of time would include the review and approval of any necessary financial information that is prepared by a CPA or a staff-level accountant, as applicable. The estimated costs associated with the preparation of the financial information required by proposed new §7.1609 are based on the following factors. First, proposed new §7.1609(c) requires each annual report to include an audit report on the financial statements performed by an independent CPA. However, proposed new §7.1609(d)(1) exempts certain administrators from this requirement. For administrators who qualify for the exemption and choose to file a certified financial statement as part of their annual report, the Department estimates that a staff-level accountant could prepare the appropriate financial statement in less than 14 hours. The salary for the staffer is estimated at the mean salary rate of $29.51 per hour, as set forth for similar accountant and auditor positions in the DOL May 2007 Texas Wage Estimates. Based upon

information available to the Department, the Department estimates that 734 of the currently licensed 751 administrators may qualify for the exemption in proposed new §7.1609(d)(1) and may be eligible to file a certified financial statement as part of the annual report due June 30, 2009. Because the preparation of a certified financial statement is typically less costly than the preparation of an audit report on financial statements prepared by an independent CPA, the Department anticipates that the majority of eligible administrators may realize cost savings as a result of the §7.1609(d)(1) exemption. Second, for administrators that do not qualify for the exemption or who choose not to file a certified financial statement as part of their annual report, §7.1609(c) requires each annual report to include an audit report on the financial statements performed by an independent CPA. The Department estimates that these administrators will typically be larger in size and may include administrators whose securities are publicly traded. Therefore, the Department anticipates that many of these administrators will have already obtained independent CPA audit reports to satisfy their own business needs. For those entities that have not already obtained such audit reports as part of their routine business practices, the Department anticipates that an independent CPA will charge certain minimum engagement costs. The Department further anticipates that an adequate audit report will typically require no less than 80 hours to prepare, at the weighted-average hourly rate of $29.51 - $60.00 per hour. The Department bases this hourly salary rate estimate on the minimum mean hourly

rate of $29.51 per hour for an accountant, as set forth in the DOL May 2007 Texas Wage Estimates, along with other factors considered by the Department, such as: (i) the experience level of the accountant; (ii) whether the accountant is employed by an independent accounting firm or a national accounting firm; (iii) the accountant's familiarity with the insurance industry in general; (iv) the accountant's prior relationship with the particular customer; and (v) the complexity of the task to be performed by the accountant. The Department anticipates that this estimated cost may increase substantially among administrators depending upon the following factors: (i) the number of hours an independent CPA needs to review a particular administrator's financial information; (ii) the size and complexity of the organization of a particular administrator; (iii) the adequacy of a particular administrator's books and records; and (iv) whether a particular administrator's internal controls are adequate. Further, the Department notes that this estimated cost may increase substantially among administrators if an administrator chooses to utilize the services of a national public accounting firm instead of the services of a particular, individual CPA.

Proposed new §7.1612 prescribes requirements related to administrator fiduciary bank accounts. Proposed new §7.1612(b) requires an administrator that receives a premium, contribution, return premium, or return contribution (premium) on behalf of an insurer, HMO, plan sponsor, or group to report the receipt of that premium to the insurer, HMO, plan sponsor, or group within a

reasonable amount of time. Proposed new §7.1612(c) requires an administrator to establish at least one fiduciary bank account to hold a premium collected or received by the administrator pursuant to proposed new §7.1612 . Proposed new §7.1612(d) requires each fiduciary bank account to be established and styled as an escrow account. Proposed new §7.1612(e) requires an administrator to maintain each fiduciary bank account at a financial institution that is organized under the laws of the United States or any state thereof. The financial institution must also be regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies. Further, proposed new §7.1612(e) provides that a fiduciary bank account may only consist of one or more of the following types of investments: (i) cash and cash equivalents, including savings accounts, checking accounts, money market accounts, and certificates of deposit; (ii) non-assessable money market mutual funds that are primarily invested in United States government securities; and (iii) other investments of substantially similar quality, as approved by the Commissioner. Proposed new §7.1612(f) requires an administrator to maintain detailed accounting records for each fiduciary bank account it establishes or maintains. Proposed new §7.1612(g) requires an administrator to provide a copy of all records relating to the account activity of an insurer, HMO, plan sponsor, or group in a fiduciary bank account to that insurer, HMO, plan sponsor, or group, upon its reasonable request. The requirements of proposed new §7.1612 only apply to an administrator that collects a premium on

behalf of an insurer, HMO, plan sponsor, or group. Thus, if an administrator does not collect such premium, there will be no compliance costs for the administrator. For administrators that must comply with proposed new §7.1612, the probable costs will vary substantially among administrators. This cost variation will be based upon the business decisions made by individual administrators, including the following factors: (i) the specific banking institution the administrator chooses for the establishment of a fiduciary account; (ii) whether the administrator uses more than one banking institution to establish a fiduciary account; (iii) the size of the amounts maintained in a fiduciary account; (iv) the number of other accounts held by the administrator at a particular banking institution; (v) whether an administrator currently utilizes an accounting system for premium collected; (vi) whether an administrator currently reports on a routine basis the collection of premium to particular insurers, HMOs, plan sponsors, or groups; (vii) whether an administrator currently provides accounting records related to collected premium to a particular insurer, HMO, plan sponsor, or group; and (viii) in what manner an administrator currently maintains collected premium. The reporting, notification, and accounting requirements in proposed new §7.1612 are consistent with prudent business practices. Therefore, the Department does not anticipate that most administrators collecting premium will need to make significant changes to their current collection and accounting methods, systems, practices, and procedures. Additionally, certain administrators may already have fiduciary accounts established to hold

premiums and may already provide accounting information to particular insurers, HMOs, plan sponsors, or groups related to the premium collected on their behalf. Further, §7.1612 does not dictate the precise methods or procedures that must be utilized by an administrator. This means that each administrator is free to choose the most economical means of complying with the §7.1612 requirements.

Proposed new §7.1613(a) requires each administrator providing administrative services in Texas on behalf of an insurer to enter into a written agreement with that insurer. Proposed new §7.1613(c), (d), (e), and (f) prescribe specific provisions that must be included in a written agreement entered into pursuant to proposed new §7.1613(a) and (b). Proposed new §7.1613(g) permits a master services agreement to be used to satisfy the requirements of proposed new §7.1613. Proposed new §7.1613(i) requires each such written agreement to meet the requirements of proposed new §7.1613 no later than September 1, 2009. Finally, proposed new §7.1613(b) provides an administrator subcontractor the option of meeting the requirements of proposed new §7.1613 by entering into a written agreement with an administrator contractor only. The written agreement, however, must meet the requirements of Chapter 4151 and proposed new §7.1613. The Department anticipates that the probable costs for complying with proposed new §7.1613 will vary substantially among administrators, depending upon: (i) the number of times a particular function is delegated; (ii) who a particular function is delegated to; (iii) the complexity of an administrator's plan of operation; (iv) how many insurers an administrator

performs services on behalf of; and (v) whether an administrator already has existing written agreements with particular insurers or other administrators. The minimum contracting requirements in proposed new §7.1613 are consistent with prudent business practices. Therefore, the Department does not anticipate that most administrators will need to make significant changes to their current contracts with insurers or other administrators in order to comply with the §7.1613 requirements. For those administrators that have existing written agreements with particular insurers or other administrators, the Department anticipates that an attorney could, in less than three hours per written agreement, (i) review those written agreements, (ii) draft any new §7.1613 provisions, and (iii) finalize those written agreements. The maximum estimated cost for these functions is $168.00. This is based on a salary for an attorney at the mean salary rate of $57.73 per hour, as set forth in the DOL May 2007 Texas Wage Estimates. For those administrators that must execute a new written agreement in order to comply with proposed new §7.1613, the Department anticipates that the costs for an attorney to prepare such an agreement should be less than $230 per written agreement. This is based on the following factors. Proposed new §7.1613 requires minimal information to be included in a written agreement between an administrator and an insurer, such as a description of the functions to be performed by the administrator. As such, the Department anticipates that an attorney could draft a new written agreement that complies with proposed new §7.1613 and finalize each agreement in less than four hours. This is also based

on the mean salary rate of $57.73 per hour for the attorney, as set forth in the DOL May 2007 Texas Wage Estimates. Additionally, because proposed new §7.1613 does not dictate the format of the written agreement, each administrator is free to choose the most economical means of compliance. This includes utilizing master services agreements. The Department anticipates that an administrator will pass on any costs associated with the contracting requirements to the insurer the administrator performs functions on behalf of or to another administrator. The Department further anticipates that this will significantly decrease the administrator's compliance costs.

Proposed new §7.1615 prescribes requirements related to the transfer of books and records upon the termination of a relationship with an administrator. Proposed new §7.1615(a) requires an administrator to provide books and records to a successor administrator no later than 30 days from the date of the termination of the relationship or written agreement with an insurer, HMO, plan sponsor, or group, unless otherwise provided by the Commissioner. If there is not a successor administrator, or if the successor administrator is unknown at the time of the required transfer, the set or copy of the books and records must be provided to the insurer, HMO, plan sponsor, or group. Proposed new §7.1615(b) requires the books and records to be transferred in an organized and usable manner. Proposed new §7.1615(c) requires the allocation of the payment of costs associated with providing the insurer’s books and records to be addressed in the written agreement between the insurer and the administrator. Proposed

new §7.1615(d) requires an administrator to provide notice to the Department of the termination of a relationship or written agreement with an insurer, HMO, plan sponsor, or group no later than thirty days from the date the administrator first learns of the termination. Proposed new §7.1615(e) allows an administrator subcontractor to comply with the requirements of §7.1615 by providing a complete and accurate original set or a complete and accurate copy or image of the original set of the insurer's, HMO's, plan sponsor's, or group's books and records to the administrator contractor. The administrator subcontractor must also provide written notice to the Department of the termination of the relationship or written agreement with the administrator contractor, no later than thirty days from the date the administrator subcontractor first learns of the termination. The Department anticipates that the total probable costs for complying with the §7.1615 notification requirements will be less than $60. This is based upon a member of an administrator's administrative staff preparing the necessary information in less than one hour. The salary for the staffer is estimated at the mean salary rate of $14.13 per hour, as set forth for similar office support and administrative positions in the DOL May 2007 Texas Wage Estimates. Additionally, the Department estimates that a member of an administrator's management staff could review and approve the prepared information in less than one hour. The salary of this staffer is estimated at the mean salary rate of $44.87 per hour, as set forth for similar management positions in the DOL May 2007 Texas Wage Estimates. The costs of compliance

associated with the copying and transfer requirements of proposed new §7.1613 will vary substantially among administrators depending upon the following factors: (i) how often an administrator's relationship or written agreement with a particular insurer, HMO, plan sponsor, or group, or other administrator terminates; (ii) the volume of books and records that are in the possession of a particular administrator; (iii) the number of insurers, HMOs, plan sponsors, or groups that a particular administrator performs administrative services for; (iv) how often a particular administrator further delegates its administrative duties to another administrator; (v) the technological capabilities of a particular administrator; and (vi) whether a particular administrator utilizes electronic record storage and maintenance. Proposed new §7.1615 does not require the copying or transferring of books and records in a specific manner. Therefore, each administrator has the flexibility to choose the most economical means of complying with the §7.1615 requirements. Proposed new §7.1615(c) requires the written agreement between the administrator and the insurer to address the costs associated with the transfer of the insurer’s books and records. Therefore, each administrator has the flexibility to negotiate the most economical means of complying with the §7.1615 requirements. This provides each administrator the opportunity to significantly decrease its own compliance costs.

Proposed new §7.1617 requires an administrator to pay to the Department a non-refundable fee of $500 for the expenses of an examination conducted under the Insurance Code §4151.201. The costs associated with §7.1617 will

vary substantially among administrators depending upon how often an administrator is examined by the Department. Whether or not the Department will examine a particular administrator will depend upon a variety of factors that will vary among administrators, including: (i) if there are indications that the administrator has not complied with regulatory requirements; (ii) if there is a substantial increase in complaints involving the administrator; or (iii) if there is any evidence of public harm caused by the administrator.

However, each administrator has the information necessary to estimate its own costs of compliance with proposed new §7.1609, §7.1612, §7.1613, §7.1615, §7.1617. Any other costs to comply with these proposed new rules result from the legislative enactment of Chapter 4151 and are not a result of the adoption, enforcement, or administration of the proposal.

Proposed New §7.1610 Requirements for Certain Administrators Subject to the Education Code §22.004(g) and (h). Proposed new §7.1610 provides an option to an insurer or HMO that (i) holds itself out as or acts as an administrator and (ii) that is subject to the Education Code §22.004(g) and (h). Such as administrator may meet the audited financial statement requirements of the Education Code §22.004(g) and (h) by either: (i) filing an annual audited financial statement in accordance with generally accepted accounting principles, as provided by the Education Code §22.004(h); or (ii) by providing a copy of the financial statement for the preceding calendar year that was prepared by an independent certified public accountant and filed with the Department in

compliance with the requirements of §7.18 (relating to the National Association of Insurance Commissioners Accounting Practices and Procedures Manual) and §7.85 (relating to Audited Financial Reports). The Education Code §22.004(g) requires an insurer, a company subject to the Insurance Code Chapter 842, or an HMO that issues a policy or contract under this section and any person that assists the school district in obtaining or managing the policy or contract for compensation to provide an annual audited financial statement to the school district showing the financial condition of the insurer, company, organization, or person. The Education Code §22.004(h) requires the annual audited financial statement to be made in accordance with rules adopted by the Commissioner or with generally accepted accounting principles, as applicable. Proposed new §7.1610 only applies to insurers or HMOs that: (i) hold themselves out as or act as administrators; (ii) are subject to the Education Code §22.004(g) and (h); and (iii) opt to comply with the audited financial statement requirements of the Education Code §22.004(g) and (h) by providing a copy of the financial statement for the preceding calendar year that was prepared by an independent certified public accountant and filed with the Department in compliance with the requirements of §7.18 (relating to the National Association of Insurance Commissioners Accounting Practices and Procedures Manual) and §7.85 (relating to Audited Financial Reports). There will be no §7.1610 compliance costs for any other administrator or for any insurer or HMO that holds itself out or acts as an administrator but chooses not to utilize the filing option provided by

§7.1610. This is because the Commissioner has adopted special accounting rules that apply to insurers and HMOs, commonly referred to as statutory accounting principles. Further, insurers and HMOs may obtain an audit on their financial statements using either generally accepted accounting principles or statutory accounting principles. However, the Commissioner has not adopted accounting rules for any other administrator entity type. Generally accepted accounting principles are the only body of accounting rules that apply to other administrator entity types. There will be costs of compliance with §7.1610 for an insurer or HMO administrator that chooses to comply with its requirements. The Department has developed estimated costs for compliance with §7.1610 based on costs that have been previously used by the Department for similar compliance requirements. Individual administrators that identify, based on their own operations, differing costs for those cost components will be able to calculate their particular costs using the Department's cost analysis approach. The Department estimates the total §7.1610 copy costs should be less than $15 - $25 per financial statement filed. This is based on the following factors. The Department assumes that each copied page costs $0.10. The Department estimates that an average financial statement filed in compliance with §7.18 (relating to the National Association of Insurance Commissioners Accounting Practices and Procedures Manual) and §7.85 (relating to Audited Financial Reports) will contain an average of 15 - 25 pages. The costs associated with the delivery of a financial statement to a school district will vary among

administrators, depending on: (i) the number of school districts that an administrator delivers its financial statement to; and (ii) the administrator's chosen method of delivery. Each administrator has the information necessary to estimate its own compliance costs. Any other costs to comply with proposed new §7.1610 result from the legislative enactment of the Education Code §22.004 and are not a result of the adoption, enforcement, or administration of the proposal.

Proposed New §7.1611 Requirements for Certain Insurers. Proposed new §7.1611 prescribes operational review and on-site audit requirements for certain insurers utilizing the services of an administrator. Proposed new §7.1611(a) requires an insurer to review the operations of each of its administrators that, in the aggregate, administers benefits in Texas on its behalf for more than 100 certificate holders, injured employees, plan participants, or policyholders. This review is required no less than two times each fiscal year. Also, §7.1611(a) allows a review to be conducted on the premises of the insurer or at another location designated by the insurer and through electronic means. Proposed new §7.1611(b) requires an insurer to conduct an on-site audit of each of its administrators that, in the aggregate, administers benefits in Texas on its behalf for more than 100 certificate holders, injured employees, plan participants, or policyholders. This on-site audit is required to be conducted no less than once every two year fiscal years. Proposed new §7.1611(c) permits an insurer to

review the operations of an administrator only one time in the same fiscal year in which the insurer conducts an on-site audit of the same administrator. Proposed new §7.1611(d) and (e) prescribe the specific requirements that an insurer review and on-site audit must meet. Proposed new §7.1611(f) permits a review or on-site audit to be performed by an insurer or the insurer's designated representative. Proposed new §7.1611(g) provides an insurer with the option of meeting the requirements of proposed new §7.1611 for an administrator subcontractor by reviewing and auditing the administrator contractor only. This, however, is permissible only under the following two circumstances: (i) the information supplied to the insurer by the administrator contractor includes all necessary and relevant information relating to the particular administrator subcontractor; and (ii) there is no evidence of material non-compliance by the particular administrator subcontractor. Lastly, proposed new §7.1611(h) requires an insurer to maintain all information and documentation related to a review or on-site audit for at least five years from the date of the review or on-site audit. The requirements of proposed new §7.1611 only apply to an insurer who utilizes the services of an administrator that, in the aggregate, administers benefits in Texas on the insurer’s behalf for more than 100 certificate holders, injured employees, plan participants, or policyholders. There will be no compliance costs for an insurer that does not utilize an administrator that, in the aggregate, administers benefits in Texas on the insurer’s behalf for more than 100 certificate holders, injured employees, plan participants, or policyholders. There will be

associated compliance costs for an insurer that does utilize an administrator that, in the aggregate, administers benefits in Texas on the insurer's behalf for more than 100 certificate holders, injured employees, plan participants, or policyholders. The Department anticipates that the probable costs of compliance with proposed new §7.1611 will vary substantially among insurers depending upon the following factors: (i) the number of administrators the insurer is required to review and audit; (ii) the size and complexity of the organization of each administrator the insurer is required to review and audit; (iii) the number of hours an insurer needs to review a particular administrator's information; (iv) the adequacy of each administrator's books and records; (v) whether an administrator's internal controls are adequate; (vi) whether the insurer is already reviewing and auditing a particular administrator; (vii) whether the insurer is able to review the administrator through electronic means; and (viii) whether an insurer discovers substantial problems during a review or audit, including the depth and complexity of those problems. The §7.1611 review and auditing requirements are consistent with prudent business practices. Therefore, the Department does not anticipate that most insurers utilizing the services of an administrator will need to make significant changes to their current review and auditing methods, systems, practices, and procedures. Additionally, certain insurers may already have certain review or auditing procedures in place that meet all or the majority of the §7.1611 requirements. Proposed new §7.1611 does not dictate the precise methods, practices, systems, or procedures that

must be utilized by an insurer during its review or audit of an administrator. Therefore, each insurer has the flexibility to use the most economical means of compliance with the §7.1611 requirements. In addition, §7.1611 provides options for compliance with the various requirements. Therefore, insurers are able to select options that will result in less costs being expended, such as performing the review through electronic means. First, proposed new §7.1611(a) permits an insurer to conduct a review of an administrator on its own premises or at another designated location. This allows an insurer to choose the most economical location for performing its review. Second, proposed new §7.1611(c) permits an insurer to forego one review of an administrator in the same fiscal year in which the insurer audits the same administrator. This will reduce the insurer's review costs. Third, proposed new §7.1611(f) permits an on-site audit to be conducted by an insurer or an insurer's designated representative. Because the proposed new requirements do not require an on-site audit to be conducted by an actuary or an independent CPA, an insurer may use its own employees to conduct an on-site audit. This also may result in costs savings. Lastly, proposed new §7.1611(g) allows an insurer to forego an additional review and audit of an administrator subcontractor under two specific circumstances: (i) the review and audit of the administrator contractor contains adequate information about the administrator subcontractor; and (ii) there is no evidence of material non-compliance by the administrator subcontractor. This provision will result in fewer reviews and audits. The Department estimates the following probable costs for

insurers that are required to comply with proposed new §7.1611. The Department anticipates that a member of an insurer's management staff could complete a review of an administrator in less than four hours. An insurer's staffer could complete an on-site audit in a minimum of eight hours. The salary for the staffer is estimated at the mean salary rate of $44.87 per hour, as set forth for similar management positions in the DOL May 2007 Texas Wage Estimates. The Department anticipates that these estimated costs may increase substantially among administrators depending upon whether a particular insurer discovers problems during a particular review or on-site audit that requires additional review and attention. Each insurer has the information necessary to estimate its own compliance costs. Any other costs to comply with proposed new §7.1611 result from the legislative enactment of Chapter 4151 and are not a result of the adoption, enforcement, or administration of the proposal.

4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. The Government Code §2006.002(c) requires that if a proposed rule may have an economic impact on small businesses, state agencies must prepare as part of the rulemaking process an economic impact statement that assesses the potential impact of the proposed rule on small businesses and a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the rule. The Government Code §2006.001(a)(2) defines "small business" as a legal entity,

including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit, is independently owned and operated, and has fewer than 100 employees or less than $6 million in annual gross receipts. The Government Code §2006.001(a)(1) defines "micro business" similarly to "small business" but specifies that such a business may not have more than 20 employees. The Government Code §2006.002(f) requires a state agency to adopt provisions concerning micro businesses that are uniform with those provisions outlined in the Government Code §2006.002(b) - (d) for small businesses.

Analysis of Economic Impact

Administrators Subject to the Insurance Code Chapter 4151. These proposed rules will regulate administrators providing administrative services in Texas. Currently, 751 persons hold authorizations under the Insurance Code Chapter 4151. Of these, the Department estimates that approximately 38 percent may qualify as small or micro businesses under the Government Code §2006.001. In order to develop this estimate, the Department randomly sampled 5 percent of the currently licensed 751 persons holding authorizations under Chapter 4151 to determine how many of those administrators collected less than $6 million in annual gross receipts in the previous year. The Department found that approximately 38 percent of the sampled administrators reported less than $6 million in annual gross receipts in the previous year. However, the Department estimates that this percentage may be higher than the actual number

of administrators that qualify as small or micro businesses under the Government Code §2006.001 because the Department does not collect additional data that would indicate if a particular administrator is independently owned or operated. In addition to the 751 persons that currently hold authorizations under Chapter 4151, 120 insurers and HMOs are authorized to act as administrators under Chapter 4151. Of these, the Department estimates that approximately 12 may qualify as small or micro businesses under the Government Code §2006.001. The Department estimates that approximately 50 new administrator applications will be submitted annually for the next five years. Of these, the Department estimates that approximately 24 percent may qualify as small or micro businesses under the Government Code §2006.001. In order to develop this estimate, the Department randomly sampled 25 percent of the 104 applications that were submitted to the Department under Chapter 4151 over the past year. The Department found that approximately 24 percent qualify as small or micro businesses under the Government Code §2006.001. However, the Department estimates that this percentage may be higher or lower than the actual number of new applicants that will qualify as small or micro businesses under the Government Code §2006.001 because this estimate is based upon the organizational makeup of past applicants, derived from information reported in the applicant's applications. The Department considered different methodologies and determined that projecting a continuation of experience from the recent past was the best means available to the Department to provide an indication of the

organizational makeup of applicants that may apply for a certificate of authority in the future. However, the Department can not assure that these recent historical trends will continue in the future. However, all small or micro business administrators that provide administrative services in Texas will be required to comply with the proposed new rules.

As required by the Government Code §2006.002(c), the Department has determined that the proposal may have an adverse economic effect on these small or micro businesses. Adverse economic impact may result from costs associated with the proposed requirements relating to: (i) application for a certificate of authority in §7.1604; (ii) notification, reporting, and maintenance of qualifications in §7.1605, §7.1606, and §7.1607; (iii) fidelity bonds in §7.1608; (iv) annual reports in §7.1609; (v) fiduciary bank accounts in §7.1612; (vi) written contracts in §7.1613, (vii) book and record transfers in §7.1615; and (viii) application fees in §7.1604, annual report fees in §7.1609, and examination fees in §7.1617. All of these requirements are either wholly or partially the result of HB 472. HB 472 was enacted by the 80th Legislature, Regular Session, effective September 1, 2007. Therefore, any compliance costs and any resulting adverse economic impact are either wholly or partially the result of the enactment of HB 472. The Department's cost analysis and resulting estimated costs in the Public Benefit/Cost Note portion of this proposal are equally applicable to these small or micro business administrators.

Insurers Utilizing the Services of an Administrator. The proposal in §7.1611 prescribes operational review and on-site audit requirements for certain insurers. Under the proposal, an insurer is required to review and audit each of its administrators that administer benefits in Texas, in the aggregate, for more than 100 certificate holders, injured employees, plan participants, or policyholders on behalf of the insurer. Currently, 1,379 insurers are authorized to write annuity, life, health, accident, pharmacy, or workers' compensation business in this state. The Department is unable to obtain information relating to the number of these insurers that qualify as a small business or a micro business under the Government Code §2006.001 because: (i) the Department does not collect information that enables the Department to determine whether an insurer utilizes the services of an administrator in Texas; and (ii) the Department does not collect information that enables the Department to determine if a particular administrator administers, in the aggregate, benefits for more than 100 certificate holders, injured employees, plan participants, or policyholders on behalf of an insurer. However, all small or micro business insurers that utilize the services of an administrator that administers benefits in Texas, in the aggregate, for more than 100 certificate holders, injured employees, plan participants, or policyholders on behalf of the insurer will be required to comply with the requirements of §7.1611.

As required by the Government Code §2006.002(c), the Department has determined that the proposal may have an adverse economic effect on these

small or micro businesses. Adverse economic impact may result from costs associated with the proposed review and on-site audit requirements in §7.1611. These requirements are either wholly or partially the result of HB 472. HB 472 was enacted by the 80th Legislature, Regular Session, effective September 1, 2007. Therefore, any compliance costs and any resulting adverse economic impact are also either wholly or partially the result of the enactment of HB 472. The Department's cost analysis and resulting estimated costs in the Public Benefit/Cost Note portion of this proposal are equally applicable to these small or micro businesses.

Certain Administrators Subject to the Education Code §22.004(g) and (h). This proposal provides an option to an insurer or HMO that (i) holds itself out as or acts as an administrator and (ii) that is subject to the Education Code §22.004(g) and (h). Such an administrator may meet the audited financial statement requirements of the Education Code §22.004(g) and (h) by either: (i) filing an annual audited financial statement in accordance with generally accepted accounting principles, as provided by the Education Code §22.004(h); or (ii) by providing a copy of the financial statement for the preceding calendar year that was prepared by an independent certified public accountant and filed with the Department in compliance with the requirements of §7.18 (relating to the National Association of Insurance Commissioners Accounting Practices and Procedures Manual) and §7.85 (relating to Audited Financial Reports). Currently, 120 insurers and HMOs are authorized to act as administrators under Chapter

4151. Of these, the Department estimates that approximately 12 may qualify as small or micro businesses under the Government Code §2006.001. Further, the Department estimates that approximately 50 new administrator applications will be submitted annually for the next five years. Of these, the Department estimates that approximately 24 percent may qualify as small or micro businesses under the Government Code §2006.001. In order to develop this estimate, the Department randomly sampled 25 percent of the 104 applications that were submitted to the Department under Chapter 4151 over the past year. The Department found that approximately 24 percent qualify as small or micro businesses under the Government Code §2006.001. However, the Department estimates that this percentage may be higher or lower than the actual number of new applicants that will qualify as small or micro businesses under the Government Code §2006.001 because this estimate is based upon the organizational makeup of past applicants, derived from information reported in the applicant's applications. The Department considered different methodologies and determined that projecting a continuation of experience from the recent past was the best means available to the Department to provide an indication of the organizational makeup of applicants that may apply for a certificate of authority in the future. However, the Department can not assure that these recent historical trends will continue in the future. However, all small or micro business administrators that: (i) are insurers or HMOs; (ii) are subject to the requirements of the Education Code §22.004(g) and (h); and (iii) opt to comply

with §7.1610 to satisfy the audited financial statement requirements of the Education Code §22.004(h) will be required to meet the requirements of §7.1610.

As required by the Government Code §2006.002(c), the Department has determined that the proposal may have an adverse economic effect on these small or micro businesses. Adverse economic impact may result from costs associated with the proposed requirements in §7.1610 relating to providing a copy of the financial statement for the preceding calendar year that was prepared by an independent certified public accountant and filed with the Department in compliance with the requirements of §7.18 (relating to the National Association of Insurance Commissioners Accounting Practices and Procedures Manual) and §7.85 (relating to Audited Financial Reports). This requirement is either wholly or partially the result of the Education Code §22.004(g) and (h). Therefore, any costs to comply with this requirement and any adverse economic impact is either wholly or partially the result of the Education Code §22.004(g) and (h). The Department's cost analysis and resulting estimated costs in the Public Benefit/Cost Note portion of this proposal are equally applicable to these small or micro business administrators.

Regulatory Flexibility Analysis

Analysis of Whether Regulatory Flexibility Alternatives are Required.

In accordance with the Government Code §2006.002(c-1), the Department has determined that the Department is not required to prepare a regulatory flexibility analysis as required in §2006.002(c)(2) of the Government Code even though

proposed new §7.1604, §7.1605, §7.1606, §7.1607, §7.1608, §7.1609, §7.1611, §7.1612, §7.1613, §7.1615, and §7.1617 may have an adverse economic effect on small or micro businesses that are required to comply with the proposed requirements and (ii) proposed new §7.1610 may have an adverse economic effect on small or micro businesses that choose to comply with that proposed requirement. Section 2006.002(c)(2) requires a state agency, before adopting a rule that may have an adverse economic effect on small businesses, to prepare a regulatory flexibility analysis that includes the agency's consideration of alternative methods of achieving the purpose of the proposed rule. Section 2006.002(c-1) of the Government Code requires that the regulatory flexibility analysis ". . . consider, if consistent with the health, safety, and environmental and economic welfare of the state, using regulatory methods that will accomplish the objectives of applicable rules while minimizing adverse impacts on small businesses." Therefore, an agency is not required to consider alternatives that, while possibly minimizing adverse impacts on small and micro businesses, would not be protective of the health, safety, and environmental and economic welfare of the state.

Administrators Subject to the Insurance Code Chapter 4151. The general purpose of Chapter 4151 is to regulate administrators performing administrative services in Texas. Under Chapter 4151, an administrator is authorized to collect premium or contributions from and adjust and settle claims for residents of this state in connection with annuity, life, health, accident,

pharmacy, and workers' compensation benefits. In authorizing an administrator to perform these functions, Chapter 4151 requires administrators to competently perform their delegated duties, including adjusting and settling claims timely and in accordance with the requirements of the Insurance Code, the Labor Code, and rules adopted thereunder. In order to accomplish these purposes, Chapter 4151 prescribes specific licensing, reporting, bonding, and contracting requirements. The Insurance Code §4151.051 and §4151.052 prescribe the licensing requirements applicable to a person seeking to act as or hold itself out as an administrator under Chapter 4151. Further, §4151.052(b) requires an applicant or administrator to notify the Department of a change in control of ownership and of a change in material fact or circumstance that affects the applicant's or administrator's qualifications for a certificate of authority under Chapter 4151. Section 4151.055 requires an applicant to obtain, and an administrator to maintain, a fidelity bond that protects against acts of fraud or dishonesty. Section 4151.101 requires an administrator to enter into a written agreement with an insurer in order for the administrator to provide administrative services to the insurer. Sections 4151.102, 4151.253, 4151.254, and 4151.256 address specific provisions and requirements that must be met by the written agreement entered into by an administrator. Section 4151.106 requires an administrator that collects a premium to hold that premium in a fiduciary capacity. Section 4151.113 provides that an insurer shall have continuing access to its books and records so it may fulfill a contractual obligation to an insured. Finally, the Insurance Code

§4151.205 requires an administrator to file an annual report with the Department, including a financial statement. The common purpose of these requirements is to: (i) ensure that an administrator properly complies with all applicable statutes and rules; (ii) ensure that an administrator is properly monitored and held accountable for any deficiencies in its performance of delegated functions; (iii) protect the financial solvency of insurers, HMOs, plan sponsors, and groups that delegate functions to administrators; (iv) ensure the timely payment of benefits; (v) protect the public and insurance consumers of this state from the fraudulent acts of an administrator; (vi) ensure the overall health of an administrator, including the integrity of its ownership and management and its financial strength; (vii) ensure that the obligations and responsibilities of an administrator are clearly defined; and (viii) ensure that the contractual obligations to the insurance consumers of this state are timely and properly fulfilled. All of these requirements will inure to the health and economic benefit and protection of Texas health insurance consumers who are covered under a plan of an insurer, HMO, plan sponsor, or group that contracts with an administrator.

The purpose of proposed new §7.1604, §7.1605, §7.1606, §7.1607, §7.1608, §7.1609, §7.1612, §7.1613, §7.1615, and §7.1617 is to protect the health, safety, and economic welfare of the public, insurance consumers of this state, and the state of Texas generally by ensuring: (i) that applicants and administrators are honest, trustworthy, and reliable and have sufficient experience, ability, standing, and good record to make success of an

administrator probable; (ii) increased accountability and compliance with the requirements of the Insurance Code, the Labor Code, and rules adopted thereunder; (iii) that benefits are available on a timely basis and in a sufficient amount; (iv) that an insurer's, HMO's, plan sponsor's, and group's obligations to its consumers are timely and properly fulfilled; (v) the overall operational health and integrity of each administrator; (vi) greater protection of the solvency of insurers, HMOs, plan sponsors, and groups that utilize the services of administrators; and (vii) that each administrator is aware of its obligations under a written agreement with an insurer.

The proposal requires the executive officers and other comparable responsible persons of an applicant for a certificate of authority under Chapter 4151 to submit biographical affidavits to the Department and to submit complete sets of fingerprints. Because administrators often have control over or access to an insurer's, HMO's, plan sponsor's, and group's financial accounts, claims files, books and records, and premium collections, it is important that these persons are honest, trustworthy, reliable, and have the necessary qualifications to make the success of the administrator probable. By requiring the key personnel of an applicant to submit their fingerprints and criminal history to the Department, the Department is better able to protect the interests of the public and the insurance consumers of this state. Further, the proposal implements the statutory bond requirements of Chapter 4151 for an administrator. This added security helps ensure that an administrator may be made whole as a result of any malfeasance

by one of its officers or employees, thus protecting the administrator's economic viability. This should, in turn, provide an insurer, HMO, plan sponsor, or group that contracts with an administrator an additional safeguard in the event that the administrator does not properly execute its delegated functions due to the acts of one of its officers or employees. If needed, this added security should provide an administrator with the necessary tools to remedy the situation, especially where the payment of benefits or collection of premium are involved, so that the ultimate interests of the insurer, HMO, plan sponsor, or group are protected. The proposal also requires an administrator to enter into a written agreement with an insurer. These proposed contracting requirements help ensure that all parties understand their responsibilities and obligations with respect to delegated functions and establish an insurer's expectations related to the performance of a delegated duty. It is especially important for insurers to properly oversee their administrators because an insurer retains ultimate responsibility and accountability for all delegated functions under the Insurance Code, the Labor Code, and rules adopted thereunder. The more times that a particular function is delegated from one administrator to another, the greater the risk of non-performance or inadequate performance of that function. The proposed requirements are necessary to protect the interests of insurance consumers by ensuring that claims are handled appropriately and paid timely, regardless of whether an insurer engages the services of an administrator or performs the required functions itself. Additionally, the proposal addresses the transfer of an

insurer's, HMO's, plan sponsor's, and group's books and records. This is particularly important because an administrator will have access to or control of an insurer's, HMO's, plan sponsor's, or group's books and records at various times. Because an insurer, HMO, plan sponsor, or group cannot comply with the requirements of the Insurance Code, the Labor Code, or rules adopted thereunder with regard to the payment of benefits without knowing which of its claims has been paid or which of its claims remain outstanding, an insurer, HMO, plan sponsor, or group must have continuing access to its books and records. This is necessary even if the books and records are physically in the possession of one of its administrators. Additionally, an insurer, HMO, plan sponsor, or group may be placed at financial risk if it is unable to timely access its financial books and records. The proposed requirements are essential to prevent situations in which an insurer, HMO, plan sponsor, or group is denied continuous access to its own books and records upon the termination of a relationship or written agreement with an administrator. The proposal requires an administrator to submit annual reports to the Department. The submission of this information is fundamental to the Department's assessment of an administrator's ability to meet its obligations under the Insurance Code, the Labor Code, and rules adopted thereunder on a regular basis. Additionally, the regular review of an administrator will enable the Department to foresee potential financial problems or solvency issues at a much earlier date, so that corrective action can be taken as necessary.

Insurers Utilizing the Services of an Administrator. As previously stated, the general purpose of Chapter 4151 is to regulate administrators performing administrative services in Texas. In order to accomplish this purpose, Chapter 4151 requires insurers to properly oversee and monitor their administrators and to ensure competent administration of their programs. Specifically, §4151.1042 requires an insurer to conduct periodic reviews and on-site audits of each of its administrators that, in the aggregate, administers benefits in Texas on behalf of the insurer for more than 100 certificate holders, injured employees, plan participants, or policyholders.

The purpose of proposed new §7.1611 is to protect the health, safety, and economic welfare of the public, insurance consumers of this state, and the state of Texas generally by ensuring: (i) appropriate oversight of the administrators performing administrative services on behalf of insurers in Texas; (ii) increased accountability and compliance with the requirements of the Insurance Code, the Labor Code, and rules adopted thereunder; (iii) that benefits are available on a timely basis and in a sufficient amount; and (iv) that an insurer's obligations to its consumers are timely and properly fulfilled. It is especially important for insurers to properly oversee their administrators because an insurer retains ultimate responsibility and accountability for all delegated functions under the Insurance Code, the Labor Code, and rules adopted thereunder. The more times that a particular function is delegated from one administrator to another, the greater the risk of non-performance or inadequate performance of that function. The

proposed requirements are necessary to: (i) enable an insurer to better assess its ability to meet its obligations under the Insurance Code, Labor Code, and rules adopted thereunder; and (ii) protect the interests of insurance consumers by ensuring that claims are handled appropriately and paid timely, regardless of whether an insurer engages the services of an administrator or performs the required functions itself. Additionally, it is anticipated that an insurer's regular review of its administrators will enable the insurer to foresee potential financial problems or solvency issues at a much earlier date, so that appropriate corrective action can be taken. Further, it is anticipated that each insurer will establish performance goals for its administrators and review the performance of its administrators to determine if those goals are being met. This should result in financially healthier insurers, as well as more productive, efficient, and compliant administrators.

Certain Administrators Subject to the Education Code §22.004(g) and (h). The general purpose of the Education Code §22.004(g) and (h) is to: (i) ensure the financial health and integrity of an insurer, a company subject to the Insurance Code Chapter 842, or an HMO that issues a policy or contract under the Education Code §22.004 and any person that assists a school district in obtaining or managing a policy or contract issued under the Education Code §22.004; and (ii) to protect the employees of a school district covered under a group health policy purchased by the school district. The Education Code §22.004(g) requires an insurer, a company subject to the Insurance Code

Chapter 842, or an HMO that issues a policy or contract under the Education Code §22.004 and any person that assists the school district in obtaining or managing the policy or contract for compensation to provide an annual audited financial statement to the school district showing the financial condition of the insurer, company, organization, or person. The Education Code §22.004(h) provides that the audited financial statement must be made in accordance with rules adopted by the Commissioner or with generally accepted accounting principles, as applicable.

The purpose of proposed new §7.1610 is to protect the health, safety, and economic welfare of the public, insurance consumers of this state, and the state of Texas generally by providing an optional mechanism for insurers or HMOs that hold themselves out or act as administrators and are subject to the requirements of the Education Code §22.004(g) and (h) to comply with the audited financial statement requirements of the Education Code §22.004(h). The proposal provides that an insurer or HMO that is subject to (i) the requirements of §7.1605 (relating to Notification Requirements) and (ii) the requirements of the Education Code §22.004(g) may meet the requirement for an audited financial statement under the Education Code §22.004(h) by providing a copy of the financial statement for the preceding calendar year that was prepared by an independent certified public accountant and filed with the Department in compliance with the requirements of §7.18 (relating to the National Association of Insurance

Commissioners Accounting Practices and Procedures Manual) and §7.85 (relating to Audited Financial Reports).

Determination that No Regulatory Flexibility Alternatives Are Required. In order to protect the citizens of this state, it is necessary that (i) all administrators, regardless of size, comply with the requirements of Chapter 4151 and the requirements in proposed new §7.1604, §7.1605, §7.1606, §7.1607, §7.1608, §7.1609, §7.1612, §7.1613, §7.1615, and §7.1617; and (ii) all qualifying insurers, regardless of size, comply with the review and on-site audit requirements of Chapter 4151 and the new requirements imposed under §7.1611. The Department has determined that the legislative intent of Chapter 4151 is that all insurance consumers benefit from the Chapter 4151 requirements, and not just those insurance consumers (i) covered under a plan administered by larger administrators that do not qualify as small or micro businesses under the Government Code §2006.001(a)(1) and (2) or (ii) under a plan provided by larger insurers, HMOs, plan sponsors, or groups that do not qualify as small or micro businesses under the Government Code §2006.001(a)(1) and (2). The proposed rules are intended to assure that all administrators, regardless of their size, have the organizational and financial capacity to perform their delegated duties in a competent manner. This is especially important because administrators (i) are often delegated the responsibility of timely paying medical benefits and workers' compensation benefits on behalf of insurers, HMOs, plan sponsors, and groups and (ii) often

have control over an insurer's, HMO's, plan sponsor's, or group's books and records and claims files. Therefore, if an administrator fails to perform one of these delegated duties, an insurer, HMO, plan sponsor, or group may not know what actions to take to correct the deficiency and statutory requirements may go unfulfilled. This could have a negative effect on the insurance consumers of this state. Additionally, the Department carefully reviews (i) an application for a certificate of authority under Chapter 4151; (ii) an administrator's annual report; and (iii) any applicant or administrator notification related to a change in control, a change in the facts and circumstances affecting the issuance of a certificate of authority, or the transfer of books and records to ensure that all applicants and administrators, regardless of size, are capable of performing their delegated functions in compliance with Chapter 4151 and the proposed rules. The Department's review of these items will require the same amount of time, effort, and cost for an applicant or administrator qualifying as a small or micro business under the Government Code §2006.001(a)(1) and (2) as an applicant or administrator not qualifying as a small or micro business under the Government Code §2006.001(a)(1) and (2). Therefore, the requirements proposed by these new rules are consistent with the legislative intent that the requirements of Chapter 4151 apply to all administrators providing administrative services in Texas and to all qualifying insurers utilizing the services of an administrator. For these reasons, the Department has determined, in accordance with §2006.002(c-1) of the Government Code, that because the purpose of this proposal and the

authorizing statute, Chapter 4151 of the Insurance Code, is to protect the health, safety, and economic welfare of the public, insurance consumers of this state, and the state of Texas, there are no additional regulatory alternatives to the proposed requirements that will sufficiently protect the health, safety, and economic interests of the public, insurance consumers of this state, and the welfare of the state of Texas.

Additionally, in order to protect the health, safety, and economic interests of the public, insurance consumers of this state, and the welfare of the state of Texas, it is necessary that all insurers or HMOs, regardless of size, that (i) hold themselves out as or act as administrators, (ii) are subject to the Education Code §22.004(g) and (h), and (iii) choose to comply with §7.1610 to satisfy the audited financial statement requirements of the Education Code §22.004(h) meet the new requirements imposed under §7.1610. The Department has determined that the legislative intent of the Education Code §22.004(g) and (h) is to ensure the financial health and integrity of an insurer, a company subject to the Insurance Code Chapter 842, or an HMO that issues a policy or contract under the Education Code §22.004 and any person that assists a school district in obtaining or managing a policy or contract issued under the Education Code §22.004; and (ii) to protect the employees of a school district covered under a group health policy purchased by the school district. The Department has also determined that the legislative intent of the Education Code §22.004 is that all school districts and employees benefit from the §22.004 requirements, and not

just those school districts or employees that are assisted in the purchase or management of a group health insurance policy or contract by larger administrators that do not qualify as small or micro businesses under the Government Code §2006.001(a)(1) and (2). Therefore, the requirements in proposed §7.1610 are consistent with the legislative intent that the audited financial statement requirements of the Education Code §22.004(g) and (h) apply, regardless of size, to all (i) insurers, (ii) group hospital service corporations subject to the Insurance Code Chapter 842; (iii) HMOs that issue a policy or contract under the Education Code §22.004; and (iv) any person that assists a school district in obtaining or managing a policy or contract issued under the Education Code §22.004, including insurers or HMOs acting as or holding themselves out as administrators. The Department has, therefore, determined, in accordance with §2006.002(c-1) of the Government Code, that because the purpose of §7.1610 and the authorizing statute, Chapter 22 of the Education Code, is to protect the health, safety, and economic welfare of the public, insurance consumers of this state, and the state of Texas, there are no additional regulatory alternatives to the proposed §7.1610 requirement that will sufficiently protect the health, safety, and economic interests of the public, insurance consumers of this state, and the welfare of the state of Texas.

5. TAKINGS IMPACT ASSESSMENT. The Department has determined that no private real property interests are affected by this proposal and that this proposal

does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

6. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on January 5, 2009, to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comments must be simultaneously submitted to Danny Saenz, Senior Associate Commissioner for the Financial Program, Mail Code 305-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104.

The Commissioner will consider the adoption of the proposed new sections in a public hearing under Docket Number 2701, at 9:30 A.M.. on January 21, 2009, in Room 100 at the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas 78701. Written and oral comments presented at the hearing will be considered.

7. STATUTORY AUTHORITY. The new sections are proposed under the Insurance Code, the Labor Code, and the Education Code.

The Insurance Code Chapter 1272 regulates the delegation of certain functions by health maintenance organizations. The Insurance Code §1272.058

provides that a delegation agreement required by the Insurance Code §1272.052 must require the delegated entity to provide the license number of a delegated third party performing a function that requires a license as a third-party administrator under the Insurance Code Chapter 4151 or utilization review agent under Article 21.58A or another license under this code or another insurance law of this state.

The Insurance Code Chapter 1305 regulates workers' compensation health care networks. The Insurance Code §1305.008 requires a person that performs the functions of an administrator under the Insurance Code Chapter 4151 to hold a certificate of authority issued under that chapter to provide those functions under the Insurance Code Chapter 1305 for an insurance carrier.

The Insurance Code Chapter 4151 regulates administrators. The Insurance Code §4151.001 defines the terms that are used in Chapter 4151, including the terms *administrator*, *insurer*, *person*, *plan*, and *plan sponsor*. The Insurance Code §4151.002 and §4151.0021 provide exemptions from the requirements of the Insurance Code Chapter 4151 for certain persons meeting specified conditions. The Insurance Code §4151.004 provides that an insurer or health maintenance organization that is not exempt under §4151.002(3) or (4) is subject to all provisions of the Insurance Code Chapter 4151 other than the Insurance Code §4151.005, §4151.051 - §4151.054, §4151.056, and §4151.206(a)(1). The Insurance Code §4151.006 provides that the Commissioner may adopt rules that are fair, reasonable, and appropriate to

augment and implement the Insurance Code Chapter 4151, including rules establishing financial standards, reporting requirements, and required contract provisions. The Insurance Code §4151.051(a) provides that an individual, corporation, organization, trust, partnership, or other legal entity may not act as or hold itself out as an administrator unless the entity is covered by and is engaging in business under a certificate of authority issued under the Insurance Code Chapter 4151. The Insurance Code §4151.052(a) provides that an application for a certificate of authority to engage in business as an administrator must be in a form prescribed by the Commissioner. Additionally, the Insurance Code §4151.052(a) specifies the items that must be included in an application for a certificate of authority, including basic organizational documents of the applicant; a description of the applicant and the applicant's services, facilities, and personnel; an audited financial statement of the applicant covering the preceding three calendar years or any lesser period that the applicant and any predecessors of the applicant have been in existence; and any other information the Commissioner reasonably requires. The Insurance Code §4151.052(b) requires an applicant for a certificate of authority or a certificate holder under the Insurance Code Chapter 4151 to notify the Department in the manner prescribed by Commissioner rule of a change of control in the applicant's or certificate holder's ownership not later than the 30th day after the effective date of the change. Additionally, the Insurance Code §4151.052(b) requires an applicant for a certificate of authority or a certificate holder under the Insurance Code Chapter

4151 to notify the Department of any other fact or circumstance affecting the applicant's or certificate holder's qualifications for a certificate of authority in this state as required by Commissioner rule. The Insurance Code §4151.053 provides that the Commissioner shall approve an application for a certificate of authority to engage in business in this state as an administrator if the Commissioner is satisfied that granting the application would not violate a federal or state law; the financial condition of the applicant or of each person who would operate or control the applicant is such that granting a certificate of authority would not be adverse to the public interest; the applicant has not attempted to obtain the certificate of authority through fraud or bad faith; the applicant has complied with the Insurance Code Chapter 4151 and rules adopted by the Commissioner under the Insurance Code Chapter 4151; and the name under which the applicant will engage in business in this state is not so similar to that of another administrator or insurer that it is likely to mislead the public. Before the Commissioner issues an applicant a certificate of authority, the Insurance Code §4151.055(a) requires an applicant to obtain and maintain a fidelity bond that complies with the Insurance Code §4151.055 and to submit to the Commissioner proof that the applicant has obtained the fidelity bond. The Insurance Code §4151.101(a) provides that an administrator may provide services only under a written agreement with an insurer or plan sponsor. The Insurance Code §4151.101(b) provides that the Commissioner by rule may prescribe provisions that must be included in the written agreement. The Insurance Code

§4151.102(a) provides that the written agreement must include each requirement prescribed by the Insurance Code Chapter 4151, Subchapter C, except for a requirement that does not apply to any function the administrator performs. The Insurance Code §4151.102(a-1) provides that the written agreement must include a statement of the duties that the administrator is expected to perform on behalf of the insurer, and the lines, classes, or types of insurance that the administrator is authorized to administer. Additionally, under the Insurance Code §4151.102(a-1), the agreement must include, as applicable, provisions regarding claims handling and other standards relating to the business underwritten by the insurer. The Insurance Code §4151.103(a) requires an administrator and the insurer, plan, or plan sponsor to retain a copy of the written agreement as part of their official records during the term of the agreement and until the fifth anniversary of the date on which the agreement expires. The Insurance Code §4151.103(d) provides that the Commissioner shall adopt rules to address the transfer of records from one administrator to another. The Insurance Code §4151.1042(a) provides that if an insurer uses the services of an administrator, the insurer is responsible for determining the benefits, premium rates, reimbursement procedures, and claims payment procedures applicable to the coverage and for securing reinsurance, if any. Further, under the Insurance Code §4151.1042(a), an insurer is required to provide a copy of the written requirements relating to those matters to the administrator. Additionally, the responsibilities of the administrator as to any of those matters must be set forth in

the written agreement between the administrator and the insurer. The Insurance Code §4151.1042(b) provides that an insurer shall ensure competent administration of its programs. The Insurance Code §4151.1042(c) provides that if an administrator administers benefits for more than 100 certificate holders, injured employees, plan participants, or policyholders on behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the administrator. Additionally, under the Insurance Code §4151.1042(c), an insurer is required to conduct an on-site audit of the operations of the administrator at least biennially. The Insurance Code §4151.105(a) provides that if an insurer, plan, or plan sponsor uses the services of an administrator, a payment of a premium or contribution to the administrator by or on behalf of an insured or plan participant is considered to have been received by the insurer, plan, or plan sponsor, and a payment of a return premium, contribution, or claim to the administrator by the insurer, plan, or plan sponsor is not considered payment to the insured, plan participant, or claimant until the insured, plan participant, or claimant receives the payment. The Insurance Code §4151.105(b) provides that the Insurance Code §4151.105 does not limit a right of an insurer, plan, or plan sponsor against the administrator resulting from the administrator's failure to make a payment to an insured, plan participant, or claimant. The Insurance Code §4151.106(a) provides that an administrator who collects funds must identify and state separately in writing the amount of any premium or contribution specified by the insurer, plan, or plan sponsor for the coverage and provide the

information to any person who pays to the administrator a premium or contribution. The Insurance Code §4151.106(b) provides that an administrator holds in a fiduciary capacity a premium or contribution the administrator collects on behalf of an insurer, plan, or plan sponsor and a return premium the administrator receives from an insurer, plan, or plan sponsor. The Insurance Code §4151.107(a) provides that, upon receiving a premium, contribution, or return premium, an administrator shall timely deliver the funds to the person entitled to the funds according to terms of the written agreement or promptly deposit the funds in a fiduciary bank account established and maintained by the administrator. The Insurance Code §4151.107(b) provides that if premiums or contributions deposited in a fiduciary bank account were collected on behalf of more than one insurer, plan, or plan sponsor, the administrator shall maintain records that clearly record separately the deposits to and withdrawals from the account on behalf of each insurer, plan, or plan sponsor, and, upon request of an insurer, plan, or plan sponsor, provide to the insurer, plan, or plan sponsor a copy of the records relating to deposits and withdrawals on behalf of that insurer or plan. The Insurance Code §4151.107(c) provides that the requirements of the Insurance Code §4151.107(b) are in addition to requirements of any other federal or state law and do not authorize the commingling of funds if otherwise prohibited by law. The Insurance Code §4151.108(a) provides that a withdrawal from a fiduciary bank account established under the Insurance Code §4151.107 may be made only as provided in the written agreement for the purposes of delivery to an

insurer, plan, or plan sponsor entitled to payment; deposit in an account controlled and maintained in the name of the insurer, plan, or plan sponsor; transfer to and deposit in a claims payment account for payment of a claim as provided by the Insurance Code §4151.111; payment to a group policyholder for delivery to the insurer entitled to payment; payment to the administrator of the administrator's commission, fees, or charges; delivery of a return premium to any person entitled to payment, or payment of a premium for stop-loss or excess loss insurance. The Insurance Code §4151.109 prohibits an administrator from paying a claim from a fiduciary bank account established under the Insurance Code §4151.107. The Insurance Code §4151.110 provides that if an administrator has the authority to accept or reject a risk, the written agreement must address underwriting or other standards of the insurer or plan. The Insurance Code §4151.112(a) requires an administrator to maintain, at the administrator's principal administrative office, adequate books and records of each transaction in which the administrator engages with an insurer, plan, plan sponsor, insured, or plan participant. The Insurance Code §4151.112(b) requires an administrator to maintain the books and records until the fifth anniversary of the end of the term of the written agreement to which the books and records relate and in accordance with prudent standards of insurance recordkeeping. The Insurance Code §4151.113(a) provides that, for the purpose of examination, audit, and inspection, an administrator shall provide to the Commissioner and the Commissioner's designee access to the books and records maintained as

required by the Insurance Code §4151.112. The Insurance Code §4151.113(b) makes a trade secret, including the identity and address of a policyholder, certificate holder, or injured employee, confidential. The Insurance Code §4151.113(b) also permits the Commissioner to use a trade secret, including the identity and address of a policyholder, certificate holder, or injured employee in a proceeding against an administrator. The Insurance Code §4151.113(c) provides that an insurer, plan, or plan sponsor is entitled to continuing access to the books and records sufficient to permit the insurer, plan, or plan sponsor to fulfill a contractual obligation to an insured or plan participant. Further, the Insurance Code §4151.113(c) provides that the right provided by the Insurance Code §4151.113(c) is subject to any restriction included in the written agreement relating to the parties' proprietary rights to the books and records. The Insurance Code §4151.114 provides that, upon termination of the written agreement, an administrator may fulfill the requirements of the Insurance Code §4151.112 and §4151.113 by delivering the books and records to a successor administrator, or if there is not a successor administrator, to the insurer, plan, or plan sponsor, and by giving written notice to the Commissioner of the location of the books and records. The Insurance Code §4151.116 requires an insurer, plan, or plan sponsor to approve the use of any advertising relating to the business underwritten by the insurer, plan, or plan sponsor before an administrator uses such advertising. The Insurance Code §4151.201(a) provides that the Commissioner may examine an administrator with regard to its business in this

state. The Insurance Code §4151.201(b) provides that the Commissioner may designate one or more employees to perform an examination. The Insurance Code §4151.201(b) provides that the Commissioner also may have examiners conduct an on-site evaluation of the administrator's personnel and facilities and any books and records of the administrator relating to the transaction of business by and the financial condition of the administrator. The Insurance Code §4151.201(c) provides that before an examiner enters an administrator's property, the Commissioner shall give notice to the administrator of the examiner's intent to conduct an on-site evaluation. Further, under the Insurance Code §4151.201(c), the notice must be in the form required by rule adopted by the Commissioner and include the date and estimated time that the examiner will enter the administrator's property. The Insurance Code §4151.201(d) provides that an examiner shall comply with operational rules of an administrator while on the administrator's property. The Insurance Code §4151.202(a) provides that an examination under the Insurance Code §4151.201 must include a review of each existing written agreement between the administrator and an insurer or plan sponsor and the administrator's financial statements. The Insurance Code §4151.203 provides that the cost of an examination under the Insurance Code §4151.201 shall be paid from the fee collected under the Insurance Code §4151.206(a)(2) and with revenue from the maintenance tax levied under the Insurance Code Chapter 259. The Insurance Code §4151.205(a) requires an administrator, not later than June 30, to annually file with the Commissioner a

report on a form prescribed by the Commissioner. Further, under the Insurance Code §4151.205(a), the report must contain any information required by the Commissioner and must be verified by at least two officers of the administrator. The Insurance Code §4151.205(b) requires the annual report to cover the preceding calendar year. Except as provided by the Insurance Code §4151.205(f), the Insurance Code §4151.205(c) requires the annual report to include an audited financial statement performed by an independent certified public accountant. Further, under the Insurance Code §4151.205(c), an audited financial statement prepared on a consolidated basis must include a columnar consolidating or combining worksheet that shall be filed with the annual report. Additionally, the amounts shown on the consolidated audited financial report must be shown on the worksheet, the amounts for each entity must be stated separately, and explanations of consolidating and eliminating entries must be included. The Insurance Code §4151.205(d) requires the annual report to include notes to the financial statement or attachments that reflect the complete name and address of each insurer in this state with which the administrator had an agreement during the preceding fiscal year. The Insurance Code §4151.205(e) provides that information derived from an audited financial statement contained in an annual report under the Insurance Code §4151.205 is confidential and is not subject to disclosure under the Government Code Chapter 552. The Insurance Code §4151.205(f) provides that an administrator who receives less than $10 million annually as compensation for performing

administrative services and operates under written agreements subject to the Insurance Code Chapter 4151 with insurers or plan sponsors in this state is not required to file an audited financial statement under the Insurance Code §4151.205(c), but must file a financial statement certified in the manner prescribed by Commissioner rule. The Insurance Code §4151.206(a) provides that the Commissioner shall collect and an applicant or administrator shall pay to the Commissioner, in an amount to be determined by the Commissioner, a filing fee not to exceed $1,000 for processing an original application for a certificate of authority for an administrator, a fee not to exceed $500 for an examination under the Insurance Code §4151.201, and a filing fee not to exceed $200 for an annual report. The Insurance Code §4151.211(a) provides that a person may not acquire an ownership interest in an entity that holds a certificate of authority under the Insurance Code Chapter 4151 if the person is, or after the acquisition would be, directly or indirectly in control of the certificate holder, or otherwise acquire control of or exercise any control over the certificate holder, unless the person has filed with the Department under oath a biographical form for each person by whom or on whose behalf the acquisition of control is to be effected; a statement certifying that no person who is acquiring an ownership interest in or control of the certificate holder has been the subject of a disciplinary action taken by a financial or insurance regulator of this state, another state, or the United State; a statement certifying that, immediately on the change of control, the certificate holder will be able to satisfy the requirements for the issuance of a

certificate of authority; and any additional information that the Commissioner by rule may prescribe as necessary or appropriate to the public interest and the protection of the insurance consumers of this state. The Insurance Code §4151.211(b) provides that the Department may require a partnership, syndicate, or other group that is required to file a statement under the Insurance Code §4151.211(a) to provide the information required under the Insurance Code §4151.211(a) for each partner of the partnership, each member of the syndicate or group, and each person who controls the partner or member. Further, under the Insurance Code §4151.211(b), if the partner, member, or person is a corporation or the person required to file the statement under the Insurance Code §4151.211(a) is a corporation, the Department may require that the information required under the Insurance Code §4151.211(a) be provided regarding the corporation, each individual who is an executive officer or director of the corporation, and each person who is directly or indirectly the beneficial owner of more than 10 percent of the outstanding voting securities of the corporation. The Insurance Code §4151.211(c) provides that the Department may disapprove an acquisition of control if, after notice and opportunity for hearing, the Commissioner determines that immediately on the change of control the certificate holder would not be able to satisfy the requirements for the certificate of authority; the competence, trustworthiness, experience, and integrity of the persons who would control the operation of the certificate holder are such that it would not be in the interest of the insurance consumers of this state to permit the

acquisition of control; or the acquisition of control would violate the Insurance Code or another law of this state, another state, or the United States. Notwithstanding the Insurance Code §4151.211(c), the Insurance Code §4151.211(d) provides that a change in control is considered approved if the Commissioner has not proposed to deny the requested change before the 61st day after the date on which the Department receives all information required by the Insurance Code §4151.211. The Insurance Code §4151.212 provides that the Department may, in the manner prescribed by the Insurance Code §4151.056 and by the Insurance Code Chapter 4151, Subchapter G revoke, suspend, or refuse to renew the certificate of authority of a certificate holder who does not maintain the qualifications necessary to obtain a certificate of authority issued under the Insurance Code Chapter 4151. The Insurance Code §4151.253(a) provides that an administrator shall enter into a contract in connection with workers' compensation benefits for collecting premium or contributions, adjusting claims, or settling claims with the insurance carrier responsible for those claims, including the insurance carrier responsible for claims arising under policies authorized under the Insurance Code §2053.202(b). Further, a contract required by the Insurance Code §4151.253(a) may be in the form of a master services agreement. The Insurance Code §4151.253(b) requires a contract required by the Insurance Code §4151.253(a) to provide that the contract does not limit in any way the insurance carrier's authority or responsibility, including financial responsibility, to comply with each statutory or

regulatory requirement and that the administrator shall comply with each statutory or regulatory requirement relating to a function assumed by or carried out by the administrator. The Insurance Code §4151.257 provides that the Commissioner shall adopt rules to implement the requirements of the Insurance Code Chapter 4151, Subchapter F, including rules prescribing requirements for contracts and master services agreements and requirements for the payment of claims. Further, under the Insurance Code §4151.257, the rules must provide for compliance with the requirements of the Insurance Code Chapter 4151 for any contract that takes effect or has an annual anniversary date on or after January 1, 2008. The Insurance Code §4151.301 provides that the Department may deny an application for a certificate of authority or discipline the holder of a certificate of authority under the Insurance Code Chapter 4151, Subchapter G if the Department determines that the applicant or holder, individually, or through an officer, director, or shareholder has willfully violated an insurance law of this state; has intentionally made a material misstatement in the application for a certificate of authority; has obtained or attempted to obtain a certificate of authority by fraud or misrepresentation; has misappropriated, converted to the applicant's or holder's own use, or illegally withheld money belonging to an insurance carrier, as that term is defined by the Labor Code §401.011, an insurer, as that term is defined by the Insurance Code §4001.003, a health maintenance organization, or an insured, enrollee, injured employee, or beneficiary; has engaged in fraudulent or dishonest acts or practices; has

materially misrepresented the terms and conditions of an insurance policy, certificate, evidence of coverage, or contract; has been convicted of a felony; is in a financial condition, or is operating or conducting business in a manner, that would render further transaction of business in this state hazardous or injurious to insured persons or the public; has failed to comply with any judgment rendered against the applicant or holder before the 60th day after the date on which the judgment becomes final; has willfully violated a Commissioner rule; has refused to be examined or to produce accounts, records, and files for examination as required by the Insurance Code Chapter 4151 or Commissioner rule; at any time fails to meet a qualification for which issuance of the certificate of authority could have been denied had the failure then existed and been known to the Commissioner; has had a certificate of authority, license, or other authority issued by this state, another state, or the United States suspended or revoked; or has failed to timely file the annual report required by the Insurance Code §4151.205.

The 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.

The Labor Code Chapter 407 regulates workers' compensation self insurance. The Labor Code §407.001(5) defines a *qualified claims servicing contractor* as a person who provides claims service for a certified self-insurer,

who is a separate business entity from the affected certified self-insurer, and who holds a certificate of authority under the Insurance Code Chapter 4151.

The Labor Code Chapter 407A regulates workers' compensation group self insurance. The Labor Code §407A.009(a) requires an administrator or service company under the Labor Code Chapter 407A that performs the acts of an administrator as defined in the Insurance Code Chapter 4151 to hold a certificate of authority under that chapter. The Labor Code §407A.009(b) provides that an entity is required to hold only one certificate of authority under the Insurance Code Chapter 4151 if the entity acts as an administrator and a service company as defined in the Labor Code Chapter 407A and performs the acts of an administrator as that term is defined in the Insurance Code Chapter 4151. The Labor Code §407A.009(c) provides that the exemptions in the Insurance Code §4151.002(18), (19), and (20), apply to an administrator or service company under the Labor Code §407A.009. The Labor Code §415.0036(a) provides that the Labor Code §415.0036 applies to an insurance adjuster, case manager, or other person who has authority under the Labor Code, Title 5 to request the performance of a service affecting the delivery of benefits to an injured employee or who actually performs such a service, including peer reviews, performance of required medical examinations, or case management.

The Labor Code Chapter 415 addresses Texas Workers' Compensation Act administrative violations. The Labor Code §415.0036(b) provides that a

person described by the Labor Code §415.0036(a) commits an administrative violation if the person offers to pay, pays, solicits, or receives an improper inducement relating to the delivery of benefits to an injured employee or improperly attempts to influence the delivery of benefits to an injured employee, including through the making of improper threats. The Labor Code §415.0036(b) provides that §415.0036 applies to each person described by §415.0036(a) who is a participant in the workers' compensation system of this state and to an agent of such a person.

The Education Code Chapter 22 regulates school district employees, including group health benefits for school employees. The Education Code §22.004(g) provides that an insurer, a company subject to the Insurance Code Chapter 842, or a health maintenance organization that issues a policy or contract under the Education Code §22.004 and any person that assists the school district in obtaining or managing the policy or contract for compensation shall provide an annual audited financial statement to the school district showing the financial condition of the insurer, company, organization, or person. The Education Code §22.004(h) provides that an audited financial statement provided under §22.004 must be made in accordance with rules adopted by the Commissioner of Insurance or with generally accepted accounting principles, as applicable.

8. CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal:

Rule	Statute
§7.1601 - §7.1618	Education Code §22.004(g) and (h); Labor Code §407.001(5), §407A.009, and §415.0036(a) and (b); Insurance Code §1272.058, §1305.008, §4151.001, §4151.002, §4151.0021, §4151.004, §4151.006, §4151.051(a), §4151.052, §4151.053, §4151.055(a), §4151.101, §4151.102(a) and (a-1), §4151.103(a) and (d), §4151.1042, §4151.105, §4151.106, §4151.107, §4151.108, §4151.109, §4151.110 §4151.112, §4151.113, §4151.114, §4151.116, §4151.201, §4151.202, §4151.203, §4151.205, §4151.206(a), §4151.211, §4151.212, §4151.253, §4151.257, and §4151.301

9. TEXT.

§7.1601. Scope.

(a) Except as otherwise provided by this subchapter or the Insurance Code Chapter 4151, this subchapter applies to a person acting as or holding itself out as an administrator in any capacity, regardless of whether the person holds another authorization under the Insurance Code or the Labor Code.

(b) In accordance with the Insurance Code §1272.058 and the Labor Code §407A.009, an administrator performing administrative services on behalf of an HMO or a workers' compensation self-insurance group shall meet the same requirements under the Insurance Code Chapter 4151 and this subchapter as an

administrator performing administrative services on behalf of an insurer or plan sponsor.

(c) A person acting as or holding itself out as an administrator must meet the requirements of the Insurance Code Chapter 4151 and this subchapter in addition to any other requirements applicable to that person under the Insurance Code Chapters 1272 or 1305 or the Labor Code Chapters 407 or 407A and any rules adopted thereunder.

(d) This subchapter does not apply to a person acting as or holding itself out as an administrator for an ERISA qualified employee welfare benefit plan that is exempt from regulation by this state with respect to that particular employee welfare benefit plan.

§7.1602. Definitions. The following words and terms when used in this subchapter shall have the following meanings unless the context clearly indicates otherwise.

(1) Administrator--As defined in the Insurance Code §4151.001(1). The term includes administrator contractors and administrator subcontractors. The term does not include a person described by the Insurance Code §4151.002 or §4151.0021.

(2) Administrative services--Services offered or performed by an administrator.

(3) Administrator contractor--An administrator as defined in the Insurance Code §4151.001(1) who contracts or enters into an agreement with an administrator subcontractor for the performance of all or a portion of the administrative services the administrator contractor previously agreed to perform on behalf of an insurer, HMO, plan sponsor, or group. The term does not include a person described by the Insurance Code §4151.002 or §4151.0021.

(4) Administrator subcontractor--An administrator as defined in the Insurance Code §4151.001(1) who contracts or enters into an agreement with an administrator contractor for the performance of all or a portion of the administrative services the administrator contractor previously agreed to perform on behalf of an insurer, HMO, plan sponsor, or group. The term does not include a person described by the Insurance Code §4151.002 or §4151.0021.

(5) Authorization--A license, permit, certificate of authority, certificate of approval, certificate of registration, or other authorization issued by the department or the division of workers' compensation to engage in an activity regulated under the Insurance Code or the Labor Code.

(6) Claim--A demand for payment, services, or benefits under a plan.

(7) ERISA--The Employee Retirement Income Security Act of 1974, 29 United States Code §1001, et seq., including all implementing federal regulations.

(8) Fiduciary bank account--An account used to hold a premium.

(9) Generally Accepted Accounting Principles--As defined in §7.85(a)(6) of this chapter (relating to Audited Financial Reports).

(10) Generally Accepted Auditing Standards--As defined in §7.85(a)(7) of this chapter.

(11) Group--A workers' compensation self-insurance group under the Labor Code Chapter 407A.

(12) Health maintenance organization (HMO)--As defined in the Insurance Code §843.002(14).

(13) Independent Certified Public Accountant--A person meeting the standards prescribed in the Insurance Code §401.011(a) and (d).

(14) Insurer--As defined in the Insurance Code §4151.001(2).

(15) Master services agreement--A written agreement between an administrator and an insurer that generally describes the administrative services to be performed by the administrator on behalf of the insurer but which also addresses additional or customized administrative services to be provided by the administrator for certain specified clients of the insurer.

(16) Person--As defined in the Insurance Code §4151.001(3).

(17) Plan--A plan, fund, or program established, adopted, or maintained by an insurer, HMO, plan sponsor, or group to the extent that the plan, fund, or program is established, adopted, or maintained to provide:

(A) indemnification or expense reimbursement for any type of life, health, accident, or pharmacy benefit, including health care benefits, health care services, or health insurance;

(B) an individual or group annuity benefit; or

(C) workers' compensation benefits, including a medical benefit, an income benefit, a death benefit, or a burial benefit.

(18) Plan sponsor--A person, other than an insurer, HMO, or group who establishes, adopts, or maintains a plan that covers residents of this state, including a plan established, adopted, or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, an association, a committee, a joint board of trustees, or any similar group of representatives who establish, adopt, or maintain a plan.

(19) Premium--A premium, contribution, return premium, or return contribution.

(20) Records--Books, accounts, records, documents, written agreements, contracts, papers, correspondence, claims files, receipts, bills, accounting and financial information, notes, pleadings, investigatory files, trading partner agreements, or any other written or electronic material directly or indirectly relating to the business of an administrator.

§7.1603. Certificate of Authority Required.

(a) Unless a person meets an exemption under the Insurance Code §§4151.002, 4151.0021, or 4151.004, a person acting as or holding itself out as an administrator must hold a certificate of authority under the Insurance Code Chapter 4151.

(b) An administrator contractor and an administrator subcontractor must hold a certificate of authority under the Insurance Code Chapter 4151.

§7.1604. Application for Certificate of Authority.

(a) Filing of Application. An applicant who seeks a certificate of authority under the Insurance Code Chapter 4151 must file an application with the department, accompanied by the non-refundable fee of $1,000. The applicant must verify the application by attesting to the truth and accuracy of the information in the application.

(b) Forms and Fee.

(1) The commissioner adopts by reference the following forms, which comprise the application for a certificate of authority under the Insurance Code Chapter 4151, and which are available at http://www.tdi.state.tx.us/forms/form5tpa.html:

(A) Form Number FIN 489, Application for a Certificate of Authority;

(B) Form Number FIN 306, Officers and Directors Form;

(C) Form Number LHL 081, Biographical Affidavit; and

(D) Form Number LHL 082, Service of Process Form.

(2) As authorized by the Insurance Code §4151.206(a)(1), the commissioner adopts a filing fee of $1,000 to be paid by an applicant for processing an original application for a certificate of authority for an administrator. The fee is non-refundable.

(c) Registration of Name. An applicant must register its official name with the department and the Office of the Secretary of State, as applicable. If the commissioner determines that an applicant's name is too similar to a name already registered with the department, the applicant must register an alternative name with the department and the Office of the Secretary of State, as applicable.

(d) Biographical Affidavit.

(1) Each executive officer or other comparable responsible person of an applicant shall provide the department with a completed Form Number LHL 081, Biographical Affidavit, as referenced in subsection (b)(1)(C) of this section. A biographical affidavit is not required if a biographical affidavit from the individual has been filed with the department within the prior three years and contains substantially accurate information. A biographical affidavit contains substantially accurate information if the responses given by the individual in the affidavit on file with the department continue to indicate sufficient experience, ability, standing, and good record to make success of the applicant probable.

(2) Each person filing a biographical affidavit under paragraph (1) of this subsection shall comply with the requirements of Chapter 1, Subchapter D of this title (relating to Effect of Criminal Conduct).

(e) Other Information. Pursuant to the Insurance Code §4151.052(a)(5), the commissioner may require the submission of any other information the commissioner reasonably requires in determining whether to approve or disapprove an application for a certificate of authority.

§7.1605. Notification Requirements.

(a) An insurer or HMO that is acting as or holding itself out as an administrator and that is not exempt under the Insurance Code §4151.002(3) or (4) is subject to all provisions of this subchapter, except §§7.1603, 7.1604, and 7.1609(c) and (d)(1) and (2) of this subchapter (relating to Certificate of Authority Required, Application for Certificate of Authority, and Annual Report).

(b) An insurer or HMO meeting the requirements of subsection (a) of this section must provide written notification to the department that it will be acting as or holding itself out as an administrator. The notice must include:

(1) the insurer's or HMO's contact information, including its TDI company number;

(2) a narrative describing the insurer's or HMO's facilities, personnel, and experience relating to the functions the insurer or HMO will be performing as an administrator; and

(3) a list of any other states in which the insurer or HMO will be acting as or holding itself out as an administrator.

§7.1606. Requirements Related to Ownership Interest and Change of Control.

(a) For purposes of this section only, control:

(1) means the power to direct, or cause the direction of, the management and policies of a person, other than the power that results from an official position with or corporate office held by the person;

(2) may be possessed by various means, including through:

(A) ownership of voting securities;

(B) ownership by contract; or

(C) direct or indirect control of one or more persons that control an administrator; and

(3) exists if an individual or a member of an individual's immediate family, directly or indirectly, owns, controls, or holds with the power to vote 10 percent or more of the voting securities or authority of:

(A) an administrator; or

(B) another person that directly or indirectly controls an administrator, including when a person holds proxies representing 10 percent or more of the voting securities or authority of the person.

(b) Pursuant to the Insurance Code §4151.052(b), an applicant or an administrator shall notify the department in writing of a change of control in the ownership of the applicant or administrator not later than the 30th day after the effective date of the change.

(c) An applicant or administrator may not file the notification required by subsection (b) of this section until a proposed acquisition of control has been approved under the Insurance Code §4151.211.

§7.1607. Facts and Circumstances Affecting Issuance of Certificate of Authority.

(a) For purposes of this section only, a material change in fact or circumstance means any fact or circumstance that impacts the accuracy or completeness of the information filed in an applicant's or administrator's initial application for a certificate of authority under the Insurance Code Chapter 4151, including:

(1) a change in an applicant's or administrator's mailing address;

(2) a felony conviction of any executive officer or other comparable responsible person of an applicant or administrator or of any other person who directly or indirectly controls the applicant or administrator; and

(3) any administrative action, order, or judgment issued against an applicant or administrator.

(b) An administrator shall notify the department in writing of a material change in fact or circumstance not later than the 30th day from the date the administrator first becomes aware of the material change in fact or circumstance.

(c) Except as provided by §7.1606(b) of this subchapter (relating to Requirements Related to Ownership Interest and Change of Control), an applicant shall continually update the information filed in its initial application for a certificate of authority under the Insurance Code Chapter 4151, including notifying the department in writing of a material change in fact or circumstance, while the application is pending with the department.

(d) An applicant or administrator must meet the requirements of the Insurance Code Chapter 4151 and this subchapter as those requirements apply to any material change of fact or circumstance identified by an administrator pursuant to subsection (b) of this section and to any change in information identified by an applicant pursuant to subsection (c) of this section.

(e) An applicant or administrator is required to maintain the qualifications necessary to obtain a certificate of authority under the Insurance Code Chapter 4151 at all times.

§7.1608. Fidelity Bond.

(a) An applicant must obtain, and an administrator must maintain, a fidelity bond that complies with the requirements of the Insurance Code §4151.055 and this section.

(b) Applicants and administrators may only obtain a fidelity bond from a surety company authorized to engage in business in this state as a surety or an eligible surplus lines insurer in compliance with the Insurance Code Chapter 981 and rules adopted thereunder.

(c) An applicant or administrator whose fidelity bond is cancelled or terminated and not replaced with new coverage that meets the requirements of the Insurance Code §4151.055 and this section and that is effective concurrently upon the date of the cancellation or termination shall immediately inform the commissioner in writing, which in no event shall be later than ten business days from the date the applicant or administrator first becomes aware of the cancellation or termination.

§7.1609. Annual Report.

(a) Filing of Annual Report. An administrator must file an annual report with the department no later than June 30 each year, accompanied by the non-refundable fee of $200.

(b) Forms and Fee.

(1) The commissioner adopts by reference the following forms, which are available at www.tdi.state.tx.us/forms/form5tpa.html:

(A) Form Number FIN 486, Annual Report Form for Administrators Holding a Certificate of Authority under TIC 4151;

(B) Form Number FIN 487, Annual Report Form for Insurers and HMOs Subject to 28 TAC §7.1605;

(C) Form Number FIN 488, Annual Report Exhibits A-E; and

(D) Form Number FIN 490, Certification of Financial Statement.

(2) As authorized by the Insurance Code §4151.206(a)(3), the commissioner adopts a fee of $200 to be paid with the filing of the annual report. The fee is non-refundable.

(c) Audit Report. The annual report required by subsection (a) of this section must also include an audit report on the financial statements prepared by an independent certified public accountant that:

(1) reflects an audit conducted in accordance with generally accepted auditing standards or with the standards adopted by the Public Company Accounting Oversight Board, as applicable; and

(2) includes a balance sheet, an income statement, a cash flow statement; and a statement of equity.

(d) Exemption.

(1) An administrator who receives less than $10 million in compensation for providing administrative services in Texas during the preceding calendar year is exempt from complying with subsection (c) of this section for that year.

(2) An administrator qualifying for the exemption in paragraph (1) of this subsection must file a financial statement with the department that:

(A) includes a completed Form Number FIN 490, Certification of Financial Statement, as referenced in subsection (b)(1)(D) of this section; and

(B) is verified by at least two officers or other comparable responsible persons of the administrator.

(3) An administrator qualifying for the exemption in paragraph (1) of this subsection must meet all other requirements of this section.

(e) The commissioner may request additional information as necessary to determine if an administrator is operating or conducting business in a hazardous or injurious manner.

§7.1610. Financial Statements Under the Education Code.

(a) This section applies only to an insurer or HMO that:

(1) meets the requirements of §7.1605 of this subchapter (relating to Notification Requirements); and

(2) is subject to the requirements of the Education Code §22.004(g).

(b) An administrator meeting the requirements of subsection (a) of this section may comply with the requirement for an audited financial statement under

the Education Code §22.004(h) by providing a copy of the financial statement filed with the Department for the preceding calendar year that:

(1) was prepared by an independent certified public accountant and;

(2) was filed in compliance with the requirements of §7.18 of this chapter (relating to the National Association of Insurance Commissioners Accounting Practices and Procedures Manual) and §7.85 of this chapter (relating to Audited Financial Reports).

§7.1611. Operational Review and On-Site Audit.

(a) No less than two times each fiscal year, an insurer shall review the operations of each of its administrators that, in the aggregate, administers benefits in Texas on behalf of the insurer for more than 100 certificate holders, injured employees, plan participants, or policyholders. A review may be conducted on the premises of the insurer or at another location designated by the insurer and may be conducted by electronic means.

(b) No less than once every two fiscal years, an insurer shall conduct an on-site audit of each of its administrators that, in the aggregate, administers benefits in Texas on behalf of the insurer for more than 100 certificate holders, injured employees, plan participants, or policyholders.

(c) Notwithstanding subsection (a) of this section, an insurer is not required to review the operations of an administrator under subsection (a) of this

section more than one time in the same fiscal year in which the insurer conducts an on-site audit of that administrator pursuant to subsection (b) of this section.

(d) Both a review and on-site audit required under subsections (a) and (b) of this section must:

(1) assess the business practices and procedures of the administrator to ensure competent administration, including evaluating:

(A) the administrator's compliance with the Insurance Code, the Labor Code, and any rules adopted thereunder, as applicable;

(B) the administrator's compliance with the provisions of the written agreement with the insurer;

(C) the administrator's performance of claims adjudication and payment;

(D) the adequacy of the financial security maintained by the administrator, if any; and

(E) the administrator's practices and procedures for establishing the adequacy of the insurer's reserves, if any; and

(2) include a written summary of the objectives and scope of the review or on-site audit and the results of the review or on-site audit, including a corrective action plan addressing any deficiencies found during the review or on-site audit.

(e) The purpose of the on-site audit required by subsection (b) of this section is to verify the accuracy, integrity, and completeness of the information

received during a review conducted by the insurer pursuant to subsection (a) of this section. In addition to the requirements of subsection (d) of this section, an on-site audit conducted by an insurer pursuant to subsection (b) of this section must also:

(1) include a physical inspection of the administrator's place of business; and

(2) include a written assessment of the reliability of the information provided to the insurer and relied upon by the insurer when conducting a review or on-site audit of the administrator under this section.

(f) A review or on-site audit required under this section may be performed by an insurer or the insurer's designated representative.

(g) An insurer may meet the requirements of this section for an administrator subcontractor by reviewing and auditing the administrator contractor only, provided that:

(1) the information supplied to the insurer by the administrator contractor includes all necessary and relevant information relating to the administrator subcontractor; and

(2) no evidence of material non-compliance by the administrator subcontractor exists.

(h) All information and documentation related to a review or on-site audit shall be made available to the commissioner upon request and must remain on

file with the insurer for at least five years from the date of the review or on-site audit.

§7.1612. Fiduciary Bank Accounts.

(a) Pursuant to the Insurance Code §4151.106(b), an administrator shall hold all premium in a fiduciary capacity.

(b) An administrator collecting or receiving any premium shall comply with the Insurance Code §§4151.105, 4151.106, 4151.107, and 4151.108 and this section. An administrator who receives any premium on behalf of an insurer, HMO, plan sponsor, or group shall report the receipt of that premium to the insurer, HMO, plan sponsor, or group within a reasonable amount of time.

(c) An administrator shall establish at least one fiduciary bank account to hold any premium collected or received pursuant to this section.

(d) A fiduciary bank account required by subsection (c) of this section must be established and styled as an escrow account.

(e) An administrator shall maintain each fiduciary bank account at a financial institution that is organized under the laws of the United States or any state thereof, and is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies. A fiduciary bank account may only consist of one or more of the following types of investments:

(1) cash and cash equivalents, including savings accounts, checking accounts, money market accounts, and certificates of deposit;

(2) non-assessable money market mutual funds that are primarily invested in United States government securities; and

(3) other investments of substantially similar quality, as approved by the commissioner.

(f) An administrator shall maintain detailed accounting records for each fiduciary bank account that separately:

(1) record each deposit and withdrawal from the account; and

(2) identify each insurer, HMO, plan sponsor, or group for whom the account is maintained.

(g) Upon the reasonable request of an insurer, HMO, plan sponsor, or group, an administrator shall provide the insurer, HMO, plan sponsor, or group a copy of all records relating to the account activity of the insurer, HMO, plan sponsor, or group in a fiduciary bank account established or maintained by the administrator on behalf of the insurer, HMO, plan sponsor, or group.

(h) All records maintained by an administrator relating to any premium shall be subject to examination by the commissioner upon request.

(i) Pursuant to the Insurance Code §4151.109, an administrator may not pay a claim from a fiduciary bank account.

(j) This subsection does not authorize any transaction that is otherwise prohibited by law.

§7.1613. Written Agreements Between Administrators and Insurers.

(a) An administrator may not provide administrative services in Texas on behalf of an insurer unless the administrator has entered into a written agreement with the insurer that meets the requirements of the Insurance Code Chapter 4151 and this section.

(b) An administrator subcontractor may meet the requirements of this section by entering into a written agreement with the administrator contractor only, provided the written agreement meets the requirements of the Insurance Code Chapter 4151 and this section, as applicable.

(c) A written agreement entered into under this section may not be construed to limit, in any way, an insurer's ultimate accountability and responsibility for compliance with all statutory and regulatory requirements under the Insurance Code, the Labor Code, and rules adopted thereunder.

(d) A written agreement entered into under this section shall include:

(1) a requirement that the administrator must comply with the requirements of the Insurance Code, the Labor Code, and any rules adopted thereunder, including holding appropriate authorizations;

(2) a description of the administrative services the administrator is expected to provide and any applicable instructions related to the performance of those services, including references to an insurer's claims handling practices or procedures;

(3) a provision relating to the continuity of services and addressing the obligations of the administrator and the insurer under §7.1615 of this subchapter (relating to Transfer of Books and Records), including the method and manner in which the insurer and administrator will meet those requirements; and

(4) a provision addressing an insurer's obligation to review and audit the performance of its administrators under §7.1611 of this subchapter (relating to Operational Review and On-Site Audit), including the method and manner in which the insurer will meet those requirements.

(e) A written agreement entered into under this section shall also ensure that the books and records of the insurer:

(1) remain the property of the insurer at all times; and

(2) are available to the insurer or its designee at any time while in the custody of the administrator.

(f) Notwithstanding subsection (e) of this section, an administrator may retain a proprietary interest in the books and records of an insurer pursuant to the Insurance Code §4151.113(c), provided that the written agreement between the administrator and the insurer specifically identifies the items that will be subject to the administrator's proprietary interest. An administrator may not withhold, based upon a claim of proprietary interest, any portion of an insurer's books and records that would restrict the ability of the insurer to comply with statutory, regulatory, or contractual obligations.

(g) A master services agreement may be used to meet the requirements of this section.

(h) If a particular requirement under this section does not apply to an administrative service offered or performed by an administrator on behalf of an insurer, that particular requirement may be omitted from the written agreement between the administrator and the insurer. However, the remainder of the written agreement between the administrator and the insurer must comply with the Insurance Code Chapter 4151 and this section.

(i) A written agreement required under this section shall meet the requirements of this section no later than September 1, 2009.

§7.1614. Prohibited Acts.

(a) An administrator is prohibited from:

(1) misrepresenting the terms or nature of an agreement with an insurer, HMO, plan sponsor, or group;

(2) making false, misleading, or incomplete comparisons to the agreements of other administrators or persons in order to induce any person to enter into, continue, or discontinue an agreement;

(3) accepting or rejecting risk, other than under the authority of, and in accordance with, a written agreement with an insurer, HMO, plan sponsor, or group;

(4) publishing or circulating any advertising or informational material, benefit descriptions, certificates, booklets, or brochures pertaining to business underwritten by an insurer, HMO, plan sponsor, or group without advance written approval of the insurer, HMO, plan sponsor, or group;

(5) pursuant to the Labor Code §415.0036, offering to pay, paying, soliciting, or receiving an improper inducement relating to the delivery of benefits to an injured employee, if the administrator performs administrative services on behalf of a person who is a participant in the workers' compensation system of this state; and

(6) pursuant to the Labor Code §415.0036, improperly attempting to influence the delivery of benefits to an injured employee, including through the making of improper threats, if the administrator performs administrative services on behalf of a person who is a participant in the workers' compensation system of this state.

(b) An administrator may be subject to other prohibitions under the Insurance Code, the Labor Code, and rules adopted thereunder that are not specified in subsection (a) of this section.

§7.1615. Transfer of Books and Records.

(a) Unless otherwise approved by the commissioner, no later than 30 days from the date of the termination of the relationship or written agreement between an insurer, HMO, plan sponsor, or group and an administrator, the

administrator shall provide a complete and accurate original set or a complete and accurate copy or image of the original set of the insurer's, HMO's, plan sponsor's, or group's books and records:

(1) to a successor administrator; or

(2) if there is not a successor administrator or if the successor administrator is unknown at the time of the required transfer, to the insurer, HMO, plan sponsor, or group.

(b) The books and records must be transferred in an organized and usable manner.

(c) The allocation of the payment of costs associated with providing a complete and accurate original set or a complete and accurate copy or image of the original set of an insurer's books and records shall be addressed in the written agreement between the insurer and the administrator under §7.1613 of this subchapter (relating to Written Agreements Between Administrators and Insurers).

(d) An administrator shall provide written notice to the department of the termination of a relationship or written agreement with an insurer, HMO, plan sponsor, or group no later than 30 days from the date the administrator first learns of the termination.

(e) If a relationship between an administrator subcontractor and an administrator contractor terminates, the administrator subcontractor may meet the requirements of this section by:

(1) providing a complete and accurate original set or a complete and accurate copy or image of the original set of the insurer's, HMO's, plan sponsor's, or group's books and records to the administrator contractor; and

(2) providing written notice to the department of the termination of the relationship or written agreement with the administrator contractor no later than 30 days from the date the administrator subcontractor first learns of the termination.

§7.1616. Hazardous or Injurious Operating Conditions.

(a) An applicant or administrator may be considered to be operating or conducting business in a hazardous or injurious manner if the administrator or applicant:

(1) has failed to file financial statements, documents, records, or reports required under the Insurance Code Chapter 4151 or this subchapter within the time periods prescribed by the Insurance Code Chapter 4151, this subchapter, or as requested by the department pursuant to law;

(2) has filed any false or misleading financial information;

(3) is unable to pay its obligations as they become due and payable;

(4) has not maintained records sufficient to permit examiners to determine its financial condition or compliance with the Insurance Code, the Labor Code, and rules adopted thereunder;

(5) does not employ management staff with the experience, competence, or trustworthiness to conduct its operations in a safe or sound manner;

(6) employs management staff that has engaged in any unlawful activity;

(7) has not complied or is not complying with the terms of a written agreement with an insurer, HMO, plan sponsor, or group;

(8) has engaged or is engaged in a pattern of failing to settle claims in accordance with contractual, regulatory, or statutory requirements; or

(9) has engaged or is engaged in fraudulent or dishonest practices or acts.

(b) Other facts and circumstances not specified in subsection (a) of this section may also indicate that an applicant or administrator is operating in a hazardous or injurious manner.

§7.1617. Examinations.

(a) As authorized by the Insurance Code §4151.206(a)(2), the commissioner adopts a fee of $500 to be paid by an administrator for an examination under the Insurance Code §4151.201. The fee is non-refundable.

(b) Pursuant to the Insurance Code §4151.202, prior to an examiner entering the property of an administrator, written notice shall be given to the

administrator. The written notice shall include the date and estimated time the examiner will enter the property of the administrator.

§7.1618. Severability. If any section or portion of a section of this subchapter is held to be invalid for any reason, all valid parts are severable from the invalid parts and remain in effect. If any section or portion of a section is held to be invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications. To this end, all provisions of this subchapter (relating to Administrators) are declared to be severable.

10. CERTIFICATION. This agency hereby certifies that the proposed new sections have been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued at Austin, Texas, on _____, 2008.

_____
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance