SUBCHAPTER A. EXAMINATION AND FINANCIAL ANALYSIS
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28 TAC §7.1909

INTRODUCTION. The Commissioner of Insurance adopts amendments to 28 TAC §§7.25, 7.88, 7.1403, and 7.1909, concerning corporate and financial regulation.

The amendments are adopted without changes to the proposed text published in the December 11, 2020, issue of the *Texas Register* (45 TexReg 8834).

REASONED JUSTIFICATION. The amendments to §§7.25, 7.88, 7.1403, and 7.1909 remove references to "nonprofit legal services corporations" from the definitions of "Eligible insurer" and "Insurer" for regulations regarding examination and financial analysis and remove references to "prepaid legal services" from regulations regarding service of process and multiple-employer welfare arrangements. "Prepaid legal services" are comprised of both for-profit legal services, which were removed from TDI's regulation by Senate Bill 597, 78th Legislature, 2003 (SB 597), and nonprofit legal services, which were removed from TDI's regulation by Senate Bill 1623, 86th Legislature, 2019 (SB 1623).

In addition, the proposed amendments also include nonsubstantive editorial and formatting changes to conform to the agency's current style and to improve the rule's clarity, which are described in the following paragraphs. These changes include correcting

punctuation, updating citations to Insurance Code provisions that have changed due to the codification Insurance Code articles, removing the word "the" before references to specific provisions in the Insurance Code, and deleting the word "shall" or replacing it with "will."

SUMMARY OF COMMENTS. TDI did not receive any comments on the proposed amendments.

SUBCHAPTER A. EXAMINATION AND FINANCIAL ANALYSIS.

28 TAC §7.25 and §7.88.

STATUTORY AUTHORITY. The Commissioner adopts the amendments to §7.25 and §7.88 under Insurance Code §§961.002 - 961.004, as amended by SB 1623, and Insurance Code §36.001.

Insurance Code §§961.002 - 961.004, as amended by SB 1623, has nonprofit legal services providers removed from TDI's regulation.

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

TEXT.

§7.25 Out of State Books and Records.

(a) Purpose and Scope. The purpose of this section is to describe the procedure an eligible insurer must follow when it desires to relocate and maintain all or any portion of

its books, records, and accounts and its principal offices outside this state at a location within the United States. To facilitate brevity, "all or any portion of its books, records, and accounts and its principal offices" will be referred to as "records" in this section. Insurance Code Article 1.28 and this section describe the standards that an insurer must meet to be eligible to relocate its records outside this state and sets forth the information an eligible insurer must provide to the department in its notice of intent to relocate records so that the Commissioner of Insurance (Commissioner) can make an informed decision to approve or disapprove the proposed relocation. The normal records relating to the business produced by an agency of an eligible insurer are not subject to Insurance Code Article 1.28. The department interprets the term "agency" in Insurance Code Article 1.28 to mean a person described in Insurance Code Article 21.02. An eligible insurer that desires to relocate its records to an out of state location must provide the information required by subsection (d) of this section. An eligible insurance company that desires to deliver possession of its records to another person located out of state who is an affiliate of the eligible insurer must also provide the information required by subsections (e) and (f) of this section. When that person is not affiliated with the eligible insurer, the person must comply with the provisions of subsections (e) - (g) of this section. Records of a health maintenance organization relating to its quality assurance program are not subject to this section.

(b) Definitions. The following words and terms, when used in this section, have the following meanings, unless the context clearly indicates otherwise.

(1) Affiliate--As defined in Insurance Code §823.003.

(2) Domestic insurance company--As defined in Insurance Code §803.001.

(3) Eligible insurer--A domestic insurance company that is:

(A) an affiliate of an insurance holding company system; or

(B) a health maintenance organization that is an affiliate of another health maintenance organization or health care provider.

(4) Health care provider--Is the same as the term "provider" in Insurance Code §843.002.

(5) Insurance holding company system--As defined in Insurance Code §823.006.

(c) Notice of Intent to Relocate Records. An eligible insurer desiring to change the location of its records to a location outside this state must file with Financial Analysis and Examinations, 333 Guadalupe, Austin, Texas 78701 or P.O. Box 149099, Austin, Texas 78714-9099, Mail Code 303-1A an original and one copy of a notice of intent to relocate records setting forth the information required by subsection (d) of this section, accompanied by the required filing fee established in §7.1301(d)(18) of this title (relating to Fees). Alternatively, an eligible insurer complies with this section when it provides the department the information required by this section in an agreement with an affiliate, and such agreement has been approved or not disapproved as required by Insurance Code Article 21.49-1, §4.

(d) Contents of Notice of Intent to Relocate Records. The notice of intent to relocate records required by Insurance Code Article 1.28 and subsection (c) of this section must provide:

(1) the name of the eligible insurer desiring to relocate its records outside the state;

(2) the street address of the eligible insurer's principal office or offices (if there is more than one principal office, identify the activities that are performed at each

principal office; e.g., accounting, actuarial, investments, underwriting, claims, marketing, data processing, human resources and corporate matters);

(3) the street address of the location or locations of the eligible insurer's records before the proposed relocation of records (if there is more than one location, identify the records that are maintained at each location; e.g., accounting, actuarial, investments, underwriting, claims, marketing, data processing, human resources and corporate matters);

(4) the street address of the eligible insurer's principal office or offices after the proposed relocation of records (if there is more than one principal office, identify the activities that will be performed at each principal office; e.g., accounting, actuarial, investments, underwriting, claims, marketing, data processing, human resources and corporate matters);

(5) the street address of the proposed location or locations of the eligible insurer's records;

(6) a detailed description of the records that will be maintained at the proposed location or locations named in paragraph (5) of this subsection;

(7) the anticipated effective date of the proposed relocation of the eligible insurer's records;

(8) a description of the eligible insurer's affiliation with an insurance holding company system or health maintenance organizations or health care providers;

(9) if the eligible insurer is affiliated with an insurance holding company system, a statement that the eligible insurer has made the necessary filings required by the Insurance Code Article 21.49-1;

(10) if the eligible insurer is affiliated with an insurance holding company system, a statement that the eligible insurer is in compliance with the Insurance Code Article 21.49-1;

(11) if the eligible insurer is a health maintenance organization that is not affiliated with an insurance holding company system, but is affiliated with other health maintenance organizations or health care providers, the health maintenance organization must furnish the information as set forth in §7.210 of this title (relating to Form B);

(12) a description of any actual, proposed, or contemplated financial involvement with respect to the relocation of the records by an officer, director or employee or a person who is the beneficial owner, directly or indirectly, of 10% or more of the voting securities of the eligible insurer or affiliated insurance holding company system or health maintenance organization;

(13) an analysis of the benefits to the eligible insurer anticipated as a result of the relocation of the records, including the effect on the location being abandoned;

(14) a description of the effect of the relocation of the records on policyholders and claimants;

(15) a service of process form executed by the eligible insurer (see subsection (l) of this section to obtain an example of an acceptable form);

(16) a service of process form executed by a controlling person of the eligible insurer (see subsection (l) of this section to obtain an example of an acceptable form);

(17) if the records of the eligible insurer will be maintained by a person other than the eligible insurer, state the name of the person who will be maintaining the records of the eligible insurer;

(18) if a person is named in paragraph (17) of this subsection, provide the information in subsection (e) of this section; and

(19) such other related information as the department may require so that an informed determination can be made to approve or disapprove the proposed relocation of records out of state.

(e) Additional Information Required for the Relocation and Possession of Records with a Person Other than the Eligible Insurer. If the eligible insurer intends for a person other than the eligible insurer to possess and maintain its records, the following information must be included in the notice of intent to relocate records:

(1) the name of the person who will possess and maintain the records;

(2) the names of the directors, executive officers, principals or principal shareholders of the person named in paragraph (1) of this subsection;

(3) a statement describing the person's affiliation with the insurance holding company system or health maintenance organization or health care providers named in subsection (d)(8) of this section, if any;

(4) an explanation and description of control mechanisms in place to assure the effective and efficient reconciliation of the records to be maintained by the person with those corporate records maintained by the eligible insurer;

(5) an explanation of how the eligible insurer will maintain direct supervision, management and control of the records that are relocated;

(6) a copy of the agreement between the eligible insurer and the person possessing and maintaining the records. The agreement must comply with the requirements of subsection (f) of this section;

(7) a description of the additional management reporting systems and internal controls that the eligible insurer will use relative to its arrangement with the person possessing and maintaining the records of the eligible insurer; and

(8) a description of any existing computer link-up that will permit on-line access to the eligible insurer by departmental examiners, or an explanation acceptable to the Commissioner why such link-up would not be practical.

(f) Agreement Between Eligible Insurer and Person to Maintain Records. An eligible insurer must have a written agreement with the person possessing and maintaining the records of the eligible insurer.

(1) The agreement shall include:

(A) a description of the functions to be performed by the person possessing and maintaining the records;

(B) a provision that requires the records of the eligible insurer be under the eligible insurer's direct supervision, management and control;

(C) a provision authorizing the department to examine, at the eligible insurer's expense, the records and operations of the person possessing and maintaining the records of the eligible insurer at the location of such records, regarding the arrangement with the eligible insurer; and

(D) a provision requiring the person possessing and maintaining the records to fully cooperate with the department staff during an examination conducted pursuant to subparagraph (C) of this paragraph.

(2) The agreement required by this section is subject to the standards in Insurance Code Article 21.49-1, §4.

(3) If the person possessing and maintaining the records of the eligible insurer is not an affiliate of the eligible insurer under Insurance Code Article 21.49-1, the agreement between the nonaffiliated person and the eligible insurer must also comply with subsection (g) of this section.

(g) Requirements and Restrictions Applicable to Nonaffiliated Person Maintaining Records. When an eligible insurer desires to have a nonaffiliated person maintain its records, there must be a written agreement between the eligible insurer and the nonaffiliated person that contains the provisions described in subsection (f) of this section and paragraphs (1) - (8) of this subsection.

(1) Only records related to policyholder claims, policy administration and related processes may be maintained by the nonaffiliated person.

(2) Only active claims files may be maintained by a nonaffiliated person.

(3) Claim files, when closed, must be returned to the eligible insurer within 60 days of closing.

(4) Copies of active claim files will be maintained by the eligible insurer at all times, unless the Commissioner's approval of the relocation of the records finds that it would not be practical and specifically waives this requirement.

(5) Active claim files maintained by the nonaffiliated person must be provided to examiners representing the department on site within three days of request.

(6) Representatives of the nonaffiliated person responsible for the maintenance of the eligible insurer's records must be reasonably available at the location of the eligible insurer's records when examiners representing the department are at the location.

(7) The nonaffiliated person must be licensed by the department to perform the services contemplated by the arrangement with the eligible insurer.

(8) A requirement that the eligible insurer must audit the nonaffiliated person at least once each 6 months to evaluate the internal controls and compliance with the agreement between the eligible insurer and the nonaffiliated person (performance audit) with regard to the records of the eligible insurer maintained by the nonaffiliated person. Such audits shall be conducted by persons who are knowledgeable in the claims adjusting process and internal controls; auditors should include representatives of the eligible insurer's internal audit department and/or the audit committee of the board of directors of the eligible insurer; and the audit reports must be reviewed by the board of directors of the eligible insurer and the nonaffiliated person.

(h) Accepted Filing of Notice of Intent. The Commissioner may approve or disapprove the notice of intent to relocate records within 30 days after a complete notice is filed with the department. The written notice required under this section shall be considered complete and filed with the department only when all materials sufficient to allow the Commissioner to conduct an informed decision on the application, including any information subsequently requested by the Commissioner, are filed. If within 30 days after the date that the eligible insurer files its complete notice of intent to relocate records, including the applicable filing fee, the Commissioner does not request additional information and has not disapproved such notice, the notice shall be deemed approved.

(i) Relocation of Records Approved to be Located Out of State. An eligible insurer that has relocated records out of state pursuant to Insurance Code Article 1.28 and this section and desires to relocate those records to another location, must file with the department the notice of intent to relocate records required by subsection (c) of this

section. The eligible insurer may use the previously approved notice of intent to relocate records to comply with this subsection to the extent there has been no change in the information previously submitted.

(j) Articles of Incorporation or Charter. An eligible insurer that relocates its records out of state is not required to amend its articles of incorporation, charter or other organizational document to reflect the relocation to the extent there has been no change in such documents as a result of the relocation.

(k) Revocation of Authority to Relocate Records. The Commissioner, upon notice and opportunity for hearing, may limit or revoke the authority of an eligible insurer to maintain records outside this state if the eligible insurer or person possessing and maintaining the records of the eligible insurer fails or refuses to comply with a request to provide information as part of an examination, or if the Commissioner determines that the continued operations of the eligible insurer might be hazardous to policyholders, creditors or the general public.

(l) Examples of the service of process form to be executed by the eligible insurer (TDI/SOP (2000)) and the controlling person (TDI/SOP-CP (2000)) under subsection (d)(15) & (16) of this section are available from the Company Licensing and Registration Division, Texas Department of Insurance, 333 Guadalupe. P.O. Box 149104, Austin, Texas 78714-9104.

§7.88. Independent Audits of Insurer and HMO Financial Statements and Insurer and HMO Internal Control over Financial Reporting.

(a) Purpose. The purpose of this section is to improve the Texas Department of Insurance's surveillance of the financial condition of insurers and HMOs by:

(1) specifying the requirements of an annual audit by an accountant of the financial statements reporting the financial condition and the results of operations of each insurer or HMO;

(2) requiring communication of internal control related matters noted in an audit;

(3) requiring an insurer or HMO that is required to file an annual audited financial report under Insurance Code Chapter 401, Subchapter A, to have an audit committee; and

(4) requiring certain insurer or HMO management to report on internal control over financial reporting.

(b) Applicability.

(1) Except as otherwise specified in this section and in Insurance Code Chapter 401, Subchapter A, this section applies to insurers and HMOs and takes effect beginning with the annual reporting period ending December 31, 2010, which period is reflected in reports and communications required to be filed with the Commissioner during calendar year 2011, and continues in effect each year thereafter.

(2) Subsection (h)(1) of this section, relating to lead audit partner limitation, is in effect for audits of the year beginning January 1, 2010, which audits are reflected in reports and communications required to be filed with the Commissioner during calendar year 2011, and continues in effect each year thereafter.

(3) Subsection (k) of this section, relating to audit committee requirements, takes effect on September 1, 2010.

(4) Subsection (l) of this section, relating to internal audit committee requirements, is applicable beginning January 1, 2021.

(c) Definitions. The following words and terms, when used in this section, [~~shall~~] have the following meanings, unless the context clearly indicates otherwise.

(1) Accountant--An independent certified public accountant or accounting firm that meets the requirements of Insurance Code §401.011.

(2) Affiliate--Has the meaning assigned by Insurance Code §823.003.

(3) Audit committee--A committee established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or HMO or group of insurers or HMOs and audits of financial statements of the insurer or HMO or group of insurers or HMOs. At the election of the controlling person, the audit committee of an entity that controls a group of insurers or HMOs may be the audit committee for one or more of the controlled insurers or HMOs solely for the purposes of this section. If an audit committee is not designated by the insurer or HMO, the insurer's or HMO's entire board of directors constitutes the audit committee.

(4) Audited financial report--The annual audit report required by Insurance Code Chapter 401, Subchapter A.

(5) Group of insurers or HMOs--Those authorized insurers or HMOs included in the reporting requirements of Insurance Code Chapter 823, or a set of insurers or HMOs as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting.

(6) Health maintenance organization (HMO)--A health maintenance organization authorized to engage in business in this state.

(7) Insurer--An insurer authorized to engage in business in this state, including:

(A) a life, health, or accident insurance company;

(B) a fire and marine insurance company;

(C) a general casualty company;

(D) a title insurance company;

(E) a fraternal benefit society;

(F) a mutual life insurance company;

(G) a local mutual aid association;

(H) a statewide mutual assessment company;

(I) a mutual insurance company other than a mutual life insurance company;

(J) a farm mutual insurance company;

(K) a county mutual insurance company;

(L) a Lloyd's plan;

(M) a reciprocal or interinsurance exchange;

(N) a group hospital service corporation; and

(O) a stipulated premium company.

(8) Internal control over financial reporting--A process implemented by an entity's board of directors, management, and other personnel designed to provide reasonable assurance regarding the reliability of the entity's financial statements. The term includes policies and procedures that:

(A) relate to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets;

(B) provide reasonable assurance that:

(i) transactions are recorded as necessary to permit preparation of the financial statements; and

(ii) receipts and expenditures are made only in accordance with authorizations of management and directors; and

(C) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of assets that could have a material effect on the financial statements.

(9) Management--The management of an insurer or HMO or group of insurers or HMOs subject to this section.

(10) SEC--The United States Securities and Exchange Commission.

(11) Section 404--Section 404, Sarbanes-Oxley Act of 2002 (15 U.S.C. §7262), and rules adopted under that section.

(12) Section 404 report--Management's report on internal control over financial reporting as determined by the SEC and the related attestation report of an accountant.

(13) SOX-compliant entity--An entity that is required to comply with or voluntarily complies with:

(A) the preapproval requirements provided by 15 U.S.C. §78j-1(i);

(B) the audit committee independence requirements provided by 15 U.S.C. §78j-1(m)(3); and

(C) the internal control over financial reporting requirements provided by 15 U.S.C. §7262(b) and Item 308, SEC Regulation S-K.

(14) Subsidiary--Has the meaning assigned by [~~the~~] Insurance Code §823.003.

(d) Filing and extensions for filing of audited financial report.

(1) Except as provided in paragraphs (2), (3), and (4) of this subsection, an insurer or HMO that is required to have an annual audit performed by an accountant and to file an audited financial report with the Commissioner under Insurance Code Chapter 401, Subchapter A, shall file the audited financial report with the Commissioner on or before June 1 for the preceding calendar year.

(2) Except as provided in paragraphs (3) and (4) of this subsection, an insurer or HMO that, along with any affiliated insurers or HMOs, is licensed in and does business only in Texas shall file the audited financial report with the Commissioner on or before June 30 for the preceding calendar year. This paragraph does not apply to an insurer or HMO that is a member of a group comprised of one or more insurers or HMOs authorized and actually doing the business of insurance in another state that requires that an audited financial report be filed on or before June 1 for the preceding calendar year.

(3) In accordance with Insurance Code §401.004(b), the Commissioner may require an insurer or HMO to file an audited financial report on a date that precedes the June 1 deadline in paragraph (1) of this subsection or the June 30 deadline in paragraph (2) of this subsection. The Commissioner must notify the insurer or HMO of the filing date not later than the 90th day before that date.

(4) The Commissioner may grant an extension of the filing date in accordance with Insurance Code §401.004(c). An extension granted under Insurance Code §401.004(c), relating to the filing date for an audited financial report, also applies to the filing of management's report on internal control over financial reporting required under subsection (n) of this section.

(5) An insurer or HMO required to file an annual audited financial report under Insurance Code Chapter 401, Subchapter A, and this section must designate a

group of individuals to serve as its audit committee. The audit committee of an entity that controls an insurer or HMO may, at the election of the controlling person, be the insurer's or HMO's audit committee for purposes of this section.

(e) Exemption for certain foreign or alien insurers or HMOs.

(1) A foreign or alien insurer or HMO exempt under Insurance Code §401.007(a) must file with the commissioner a copy of:

(A) the audited financial report and the accountant's letter of qualifications filed with the insurer's or HMO's state of domicile at the same time these documents are filed with the state of domicile;

(B) the communication of internal control-related matters noted in the audit that is substantially similar to the communication required under subsection (j) of this section, not later than the 60th day after the date the copy of the audited financial report and accountant's letter of qualifications are filed with the commissioner; and

(C) any notification of adverse financial conditions report filed with the other state, in accordance with the filing date prescribed by Insurance Code §401.017.

(2) A foreign or alien insurer or HMO required to file management's report of internal control over financial reporting in another state is exempt from filing the report in this state under subsection (n)(1) of this section if the other state has substantially similar reporting requirements and the report is filed with the commissioner in that state in the time specified.

(f) Requirements for financial statements in audited financial report. The financial statements included in the audited financial report must be prepared in a form and use language and groupings substantially the same as the relevant sections of the annual statement of the insurer or HMO filed with the Commissioner. The financial statements

must be comparative, including amounts on December 31 of the current year and amounts as of the immediately preceding December 31, except for the first year in which an insurer or HMO is required to file the report.

(g) Scope of audit and report of accountant. An accountant must audit the financial reports provided by an insurer or HMO for purposes of an audit conducted under Insurance Code Chapter 401, Subchapter A. In addition to complying with the requirements of the Insurance Code §401.010, the accountant shall obtain an understanding of internal control sufficient to plan the audit, in accordance with "Consideration of Internal Control in a Financial Statement Audit," AU Section 319, Professional Standards of the American Institute of Certified Public Accountants. To the extent required by AU Section 319, for those insurers or HMOs required to file a management's report of internal control over financial reporting under subsection (n) of this section, the accountant shall consider the most recently available report in planning and performing the audit of the statutory financial statements. In this subsection, "consider" has the meaning assigned by Statement on Auditing Standards No. 102, "Defining Professional Requirements in Statements on Auditing Standards," or a successor document.

(h) Qualifications and independence of accountant; acceptance of audited financial report. Except as provided by Insurance Code §401.011(b) and (d), and paragraphs (1), (3), (4), (5), and (10) of this subsection, the Commissioner will accept an audited financial report from an independent certified public accountant or accounting firm that is a member in good standing of the American Institute of Certified Public Accountants; is in good standing with all states in which the accountant or firm is licensed to practice, as applicable; and conforms to the American Institute of Certified Public Accountants Code

of Professional Conduct and to the rules of professional conduct and other rules of the Texas State Board of Public Accountancy or a similar code.

(1) A lead partner or other person responsible for rendering an audited financial report for an insurer or HMO may not act in that capacity for more than five consecutive years and may not, during the five-year period after that fifth year, render an audited financial report for the insurer or HMO or for a subsidiary or affiliate of the insurer or HMO that is engaged in the business of insurance. On application made at least 30 days before the end of the calendar year, the Commissioner may determine that the limitation provided by this paragraph does not apply to an accountant for a particular insurer or HMO if the insurer or HMO demonstrates to the satisfaction of the Commissioner that the limitation's application to the insurer or HMO would be unfair because of unusual circumstances. In making the determination, the Commissioner may consider:

(A) the number of partners or individuals the accountant employs, the expertise of the partners or individuals the accountant employs, or the number of the accountant's insurance clients;

(B) the premium volume of the insurer or HMO; and

(C) the number of jurisdictions in which the insurer or HMO engages in business.

(2) On filing its annual statement, an insurer or HMO for which the Commissioner has approved an exemption under paragraph (1) of this subsection must file the approval with the states in which it is doing business or is authorized to do business and with the National Association of Insurance Commissioners. If a state other than this state accepts electronic filing with the National Association of Insurance

Commissioners, the insurer or HMO must file the approval in an electronic format acceptable to the National Association of Insurance Commissioners.

(3) In providing services, the accountant may not:

(A) function in the role of management, audit the accountant's own work, or serve in an advocacy role for the insurer or HMO; or

(B) directly or indirectly enter into an agreement of indemnity or release from liability regarding the audit of the insurer or HMO.

(4) The Commissioner may not recognize as qualified or independent an accountant, or accept an annual audited financial report that was prepared wholly or partly by an accountant, who provides an insurer or HMO at the time of the audit:

(A) bookkeeping or other services related to the accounting records or financial statements of the insurer or HMO;

(B) services related to financial information systems design and implementation;

(C) appraisal or valuation services, fairness opinions, or contribution-in-kind reports;

(D) actuarially oriented advisory services involving the determination of amounts recorded in the financial statements;

(E) internal audit outsourcing services;

(F) management or human resources services;

(G) broker or dealer, investment adviser, or investment banking services;

(H) legal services or other expert services unrelated to the audit; or

(I) any other service that the Commissioner determines to be inappropriate.

(5) Notwithstanding paragraph (4)(D) of this subsection, an accountant may assist an insurer or HMO in understanding the methods, assumptions, and inputs used in the determination of amounts recorded in the financial statement if it is reasonable to believe that the advisory service will not be the subject of audit procedures during an audit of the insurer's or HMO's financial statements. An accountant's actuary may also issue an actuarial opinion or certification on an insurer's or HMO's reserves if:

(A) the accountant or the accountant's actuary has not performed management functions or made any management decisions;

(B) the insurer or HMO has competent personnel, or engages a third-party actuary, to estimate the reserves for which management takes responsibility; and

(C) the accountant's actuary tests the reasonableness of the reserves after the insurer's or HMO's management has determined the amount of the reserves.

(6) An insurer or HMO that has direct written and assumed premiums of less than $100 million in any calendar year may request an exemption from the requirements of paragraph (4) of this subsection by filing with the Commissioner a written statement explaining why the insurer or HMO should be exempt. The Commissioner may grant the exemption if the Commissioner finds that compliance with paragraph (4) of this subsection would impose an undue financial or organizational hardship on the insurer or HMO.

(7) An accountant who performs an audit may perform non-audit services, including tax services, that are not described in paragraph (4) of this subsection or that

do not conflict with paragraph (3) of this subsection, only if the activity is approved in advance by the audit committee in accordance with paragraph (8) of this subsection.

(8) The audit committee must approve in advance all auditing services and non-audit services that an accountant provides to the insurer or HMO. The prior approval requirement is waived with respect to non-audit services if the insurer or HMO is a SOX-compliant entity or a direct or indirect wholly owned subsidiary of a SOX-compliant entity or:

(A) the aggregate amount of all non-audit services provided to the insurer or HMO is not more than five percent of the total amount of fees paid by the insurer or HMO to its accountant during the fiscal year in which the non-audit services are provided;

(B) the services were not recognized by the insurer or HMO at the time of the engagement to be non-audit services; and

(C) the services are promptly brought to the attention of the audit committee and approved before the completion of the audit by the audit committee or by one or more members of the audit committee who are the members of the board of directors to whom the audit committee has delegated authority to grant approvals.

(9) The audit committee may delegate to one or more designated members of the audit committee the authority to grant the prior approval required by paragraph (7) of this subsection. The decisions of any member to whom this authority is delegated shall be presented to the full audit committee at each of its scheduled meetings.

(10) The Commissioner may not recognize an accountant as qualified or independent for a particular insurer or HMO if a member of the board, the president, chief executive officer, controller, chief financial officer, chief accounting officer, or any

individual serving in an equivalent position for the insurer or HMO, was employed by the accountant and participated in the audit of that insurer or HMO during the one-year period preceding the date on which the most current statutory opinion is due. This paragraph applies only to partners and senior managers involved in the audit. An insurer or HMO may apply to the Commissioner for an exemption from the requirements of this paragraph on the basis of unusual circumstances.

(11) The Commissioner will not accept an audited financial report prepared wholly or partly by an individual or firm who the commissioner finds:

(A) has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act (18 U.S.C. §1961 et seq.), or a state or federal criminal offense involving dishonest conduct;

(B) has violated the insurance laws of this state with respect to a report filed under Insurance Code Chapter 401, Subchapter A, or this section;

(C) has demonstrated a pattern or practice of failing to detect or disclose material information in reports filed under Insurance Code Chapter 401, Subchapter A, or this section; or

(D) has directly or indirectly entered into an agreement of indemnity or release of liability regarding an audit of an insurer.

(12) The insurer or HMO must file, with its annual statement filing, the approval of an exemption granted under paragraph (6) or (10) of this subsection with the states in which it does business or is authorized to do business and with the National Association of Insurance Commissioners. If a state, other than this state, in which the insurer or HMO does business or is authorized to do business accepts electronic filing,

the insurer or HMO must file the approval in an electronic format acceptable to the National Association of Insurance Commissioners.

(i) Accountant's letter of qualifications. The audited financial report required under Insurance Code §401.004 must be accompanied by a letter, provided by the accountant who performed the audit, that includes the representations and statements required under Insurance Code §401.013, and a representation that the accountant is in compliance with the requirements specified in subsection (h) of this section.

(j) Communication of internal control matters noted in audit.

(1) In addition to the audited financial report required by Insurance Code Chapter 401, Subchapter A, and this section, each insurer or HMO shall provide to the Commissioner a written communication prepared by an accountant in accordance with the Professional Standards of the American Institute of Certified Public Accountants that describes any unremediated material weaknesses in its internal controls over financial reporting noted during the audit. The insurer or HMO must annually file with the Commissioner the communication required by this subsection not later than the 60th day after the date the audited financial report is filed. The communication must contain a description of any unremediated material weaknesses, as defined by Statement on Auditing Standards No. 112, "Communicating Internal Control Related Matters Identified in an Audit," or a successor document, as of the immediately preceding December 31, in the insurer's or HMO's internal control over financial reporting that was noted by the accountant during the course of the audit of the financial statements. The communication must affirmatively state if unremediated material weaknesses were not noted by the accountant.

(2) The insurer or HMO shall also provide a description of remedial actions taken or proposed to be taken to correct unremediated material weaknesses, if the actions are not described in the accountant's communication.

(k) Requirements for audit committees.

(1) This subsection does not apply to the following:

(A) a foreign or alien insurer or HMO;

(B) an insurer or HMO that is a SOX-compliant entity;

(C) an insurer or HMO that is a direct or indirect wholly owned subsidiary of a SOX-compliant entity; or

(D) a non-stock insurer that is under the direct or indirect control of a SOX-compliant entity, including pursuant to the terms of an exclusive management contract.

(2) Except as provided in paragraphs (1) and (3) of this subsection, an insurer or HMO to which Insurance Code Chapter 401, Subchapter A, applies must establish an audit committee conforming to the following criteria:

(A) an insurer or HMO with over $500 million in direct written and assumed premiums for the preceding calendar year shall establish an audit committee with an independent membership of at least 75 percent;

(B) an insurer or HMO with $300 million to $500 million in direct written and assumed premiums for the preceding calendar year shall establish an audit committee with an independent membership of at least 50 percent; and

(C) except as provided in paragraph (3) of this subsection, an insurer with less than $300 million in direct and assumed premiums for the preceding calendar

year is not required to comply with the independence requirements in this subsection for its audit committee.

(3) Notwithstanding subsection (k)(1) and (10) of this section, the Commissioner may require the insurer's or HMO's board to enact improvements to the independence of the audit committee membership if the insurer or HMO:

(A) is in a risk-based capital action level event, as described by or provided in Insurance Code Chapters 822, 841, 843, or 884 or rules adopted thereunder, including §7.402 of this title (relating to Risk-Based Capital and Surplus Requirements for Insurers and HMOs);

(B) meets one or more of the standards of an insurer or HMO considered to be in hazardous financial condition as described by or provided in Insurance Code Chapter 404, 441, or 843 or rules adopted thereunder, including Chapter 8 of this title (relating to Hazardous Condition) and §11.811 of this title (relating to Action under Insurance Code §843.157 and Insurance Code §843.461); or

(C) otherwise exhibits qualities of a troubled insurer or HMO.

(4) An insurer or HMO with direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, of less than $500 million may apply to the Commissioner for a waiver from the requirements of paragraphs (1), (2), (5), (6) and (8) - (13) of this subsection based on hardship. The insurer or HMO shall file, with its annual statement filing, the approval of a waiver under this paragraph with the states in which it does business or is authorized to do business and with the National Association of Insurance Commissioners. If a state other than this state accepts electronic filing, the insurer or HMO shall file the approval in an electronic format acceptable to the National Association of Insurance Commissioners.

(5) In this subsection, direct written and assumed premiums for the preceding calendar year must be the combined total of direct premiums and assumed premiums from non-affiliates for the reporting entities.

(6) The audit committee is directly responsible for the appointment, compensation, and oversight of the work of any accountant, including the resolution of disagreements between the management of the insurer or HMO and the accountant regarding financial reporting, for the purpose of preparing or issuing the audited financial report or related work under Insurance Code Chapter 401, Subchapter A, and this section. Each accountant shall report directly to the audit committee.

(7) The audit committee of an insurer or HMO or group of insurers or HMOs must be responsible for overseeing the insurer's or HMO's internal audit function and granting the person or persons performing the function suitable authority and resources to fulfill their responsibilities if required by subsection (l) of this section, relating to internal audit function requirements.

(8) Each member of the audit committee must be a member of the board of directors of the insurer or HMO or, at the election of the controlling person, a member of the board of directors of an entity that controls the group of insurers or HMOs as provided under paragraph (11) of this subsection and described under subsection (c)(3) of this section.

(9) To be independent for purposes of this subsection, a member of the audit committee may not, other than in his or her capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory, or other compensatory fee from the entity or be an affiliate of the entity or an affiliate of any subsidiary of the entity. To the extent of any conflict with a statute requiring

an otherwise non-independent board member to participate in the audit committee, the other statute prevails and controls, and the member may participate in the audit committee unless the member is an officer or employee of the insurer or HMO or an affiliate of the insurer or HMO.

(10) Except as provided in paragraph (3) of this subsection, if a member of the audit committee ceases to be independent for reasons outside the member's reasonable control, the member may remain an audit committee member of the responsible entity, if the responsible entity gives notice to the Commissioner, until the earlier of:

(A) the next annual meeting of the responsible entity; or

(B) the first anniversary of the occurrence of the event that caused the member to be no longer independent.

(11) To exercise the election of the controlling person to designate the audit committee under this section, the ultimate controlling person must provide written notice of the affected insurers or HMOs to the Commissioner. Notice must be made before the issuance of the statutory audit report and must include a description of the basis for the election. The election may be changed through a notice to the Commissioner by the insurer or HMO, which must include a description of the basis for the change. An election remains in effect until changed by later election.

(12) The audit committee must require the accountant who performs an audit required by Insurance Code Chapter 401, Subchapter A, and this section to report to the audit committee in accordance with the requirements of Statement on Auditing Standards No. 114, "The Auditor's Communication With Those Charged With Governance," or a successor document, including:

(A) all significant accounting policies and material permitted practices;

(B) all material alternative treatments of financial information in statutory accounting principles that have been discussed with the insurer's or HMO's management officials;

(C) ramifications of the use of the alternative disclosures and treatments, if applicable, and the treatment preferred by the accountant; and

(D) other material written communications between the accountant and the management of the insurer or HMO, such as any management letter or schedule of unadjusted differences.

(13) If an insurer or HMO is a member of an insurance holding company system, the report required by paragraph (12) of this subsection may be provided to the audit committee on an aggregate basis for insurers or HMOs in the holding company system if any substantial differences among insurers or HMOs in the system are identified to the audit committee.

(l) Internal audit function requirements.

(1) An insurer or HMO is exempt from the requirements of this subsection if:

(A) the insurer or HMO has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500 million; and

(B) the insurer or HMO is a member of a group of insurers or HMOs, the group has annual direct written and unaffiliated assumed premium including

international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1 billion.

(2) An insurer or HMO or group of insurers or HMOs subject to this subsection must establish an internal audit function providing independent, objective, and reasonable assurance to the audit committee and insurer or HMO management regarding the insurer's or HMO's governance, risk management, and internal controls. This assurance must be provided by performing general and specific audits, reviews, and tests, and by employing other techniques deemed necessary to protect assets, evaluate control effectiveness and efficiency, and evaluate compliance with policies and regulations.

(3) In order to ensure that internal auditors remain objective, the internal audit function must be organizationally independent. Specifically, the internal audit function cannot defer ultimate judgment on audit matters to others and must appoint an individual to head the internal audit function who has direct and unrestricted access to the board of directors. Organizational independence does not prevent dual-reporting relationships.

(4) The head of the internal audit function must report to the audit committee regularly but no less than annually on the periodic audit plan, factors that may adversely impact the internal audit function's independence or effectiveness, material findings from completed audits, and the appropriateness of corrective actions implemented by management as a result of audit findings.

(5) If an insurer or HMO is a member of an insurance holding company system or included in a group of insurers or HMOs, the insurer or HMO may satisfy the

internal audit function requirements set forth in this section at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level.

(m) Prohibited conduct in connection with preparation of Required Reports and documents.

(1) A director or officer of an insurer or HMO may not, directly or indirectly:

(A) make or cause to be made a materially false or misleading statement to an accountant in connection with an audit, review, or communication required by Insurance Code Chapter 401, Subchapter A, or this section; or

(B) omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review, or communication required under Insurance Code Chapter 401, Subchapter A, or this section.

(2) An officer or director of an insurer or HMO, or another person acting under the direction of an officer or director of an insurer or HMO, may not directly or indirectly coerce, manipulate, mislead, or fraudulently influence an accountant performing an audit under Insurance Code Chapter 401, Subchapter A, or this section if that person knew or should have known that the action, if successful, could result in rendering the insurer's or HMO's financial statements materially misleading. For purposes of this paragraph, actions that could result in rendering the insurer's or HMO's financial statements materially misleading include actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead, or fraudulently influence an accountant:

(A) to issue or reissue a report on an insurer's or HMO's financial statements that is not warranted and would result in material violations of statutory accounting principles prescribed by the Commissioner, generally accepted auditing standards, or other professional or regulatory standards;

(B) not to perform an audit, review, or other procedure required by generally accepted auditing standards or other professional standards;

(C) not to withdraw an issued report; or

(D) not to communicate matters to an insurer's or HMO's audit committee.

(n) Report of internal control over financial reporting.

(1) Each insurer or HMO required to file an audited financial report under Insurance Code Chapter 401, Subchapter A, and this section that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, of $500 million or more must prepare a report of the insurer's or HMO's or group of insurers' or HMOs' internal control over financial reporting. The report must be filed with the Commissioner with the communication described by subsection (j) of this section. The report of internal control over financial reporting shall be filed with the Commissioner as of the immediately preceding December 31.

(2) Notwithstanding the premium threshold under paragraph (1) of this subsection, the Commissioner may require an insurer or HMO to file the management's report of internal control over financial reporting if the insurer or HMO is in any risk-based capital level event or meets one or more of the standards of an insurer or HMO considered to be in hazardous financial condition as described by or provided in Insurance Code

Chapter 404, 441, 822, 841, 843, or 884 or rules adopted thereunder, including §7.402 of this title, Chapter 8 of this title, and §11.811 of this title.

(3) An insurer or HMO or a group of insurers or HMOs may file the insurer's or HMO's or the insurer's or HMO's parent's Section 404 report and an addendum if the insurer or HMO or group of insurers or HMOs is:

(A) directly subject to Section 404;

(B) part of a holding company system whose parent is directly subject to Section 404;

(C) not directly subject to Section 404 but is a SOX-compliant entity; or

(D) a member of a holding company system whose parent is not directly subject to Section 404 but is a SOX-compliant entity.

(4) A Section 404 report described by paragraph (3) of this subsection must include those internal controls of the insurer or HMO or group of insurers or HMOs that have a material impact on the preparation of the insurer's or HMO's or group of insurers' or HMOs' audited statutory financial statements, including those items listed in Insurance Code §401.009(a)(3)(B) - (H) and (b). The addendum must be a positive statement by management that there are no material processes excluded from the Section 404 report with respect to the preparation of the insurer's or HMO's or group of insurers' or HMOs' audited statutory financial statements, including those items specified in Insurance Code §401.009(a)(3)(B) - (H) and (b). If there are internal controls of the insurer or HMO or group of insurers or HMOs that have a material impact on the preparation of the insurer's or HMO's or group of insurers' or HMOs' audited statutory financial statements and those

internal controls are not included in the Section 404 report, the insurer or HMO or group of insurers or HMOs may either file:

(A) a report under this subsection; or

(B) the Section 404 report and a report under this subsection for those internal controls that have a material impact on the preparation of the insurer's or HMO's or group of insurers' or HMOs' audited statutory financial statements not covered by the Section 404 report.

(5) The insurer's or HMO's management report of internal control over financial reporting must include:

(A) a statement that management is responsible for establishing and maintaining adequate internal control over financial reporting;

(B) a statement that management has established internal control over financial reporting and an opinion concerning whether, to the best of management's knowledge and belief, after diligent inquiry, its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

(C) a statement that briefly describes the approach or processes by which management evaluates the effectiveness of its internal control over financial reporting;

(D) a statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

(E) disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of the immediately preceding December 31;

(F) a statement regarding the inherent limitations of internal control systems; and

(G) signatures of the chief executive officer and the chief financial officer or an equivalent position or title.

(6) For purposes of paragraph (5)(E) of this subsection, an insurer's or HMO's management may not conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there is one or more unremediated material weaknesses in its internal control over financial reporting.

(7) Management must document, and make available upon financial condition examination, the basis of the opinions required by paragraph (5) of this subsection. Management may base opinions, in part, on its review, monitoring, and testing of internal controls undertaken in the normal course of its activities.

(8) Management has discretion about the nature of the internal control framework used, and the nature and extent of the documentation required by paragraph (7) of this subsection, in order to form its opinions in a cost-effective manner and may include an assembly of or reference to existing documentation.

(9) The management's report of internal control over financial reporting required by this subsection and any supporting documentation provided in the course of a financial condition examination are considered examination information pursuant to Insurance Code §401.058 and information described by Insurance Code §401.201.

(o) Transition dates.

(1) An insurer or HMO or group of insurers or HMOs whose audit committee as of September 1, 2010, is not subject to the independence requirements of subsection

(k) of this section because the total written and assumed premium is below the threshold specified in subsection (k)(2)(A) or (B) of this section and that later becomes subject to one of the independence requirements because of changes in the amount of written and assumed premium, has one year following the year in which the written and assumed premium exceeds the threshold amount to comply with the independence requirements. An insurer or HMO that becomes subject to one of the independence requirements as a result of a business combination must comply with the independence requirements not later than the first anniversary of the date of the acquisition or combination.

(2) An insurer or HMO required to file an audited financial report under Insurance Code Chapter 401, Subchapter A, and this section that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, of $500 million or more for the reporting period ending December 31, 2010, and that has not had total written premium at the $500 million or more premium threshold amount in any prior calendar year reporting period must comply with the reporting requirements in subsection (n) of this section no later than two years after the year in which the written premium exceeds the threshold amount required to file a report.

(3) An insurer or HMO or group of insurers or HMOs that is not required by subsection (n)(1) of this section to file a report beginning with the reporting period ending December 31, 2010, because the total written premium is below the threshold amount, and that later becomes subject to the reporting requirements, has two years after the year in which the written premium exceeds the threshold amount required to file a report. An insurer or HMO acquired in a business combination must comply with the reporting

requirements not later than the second anniversary of the date of the acquisition or combination.

(4) An insurer or HMO or group of insurers or HMOs that no longer qualifies for the exemption in subsection (l)(1) of this section has one year after the year the threshold is exceeded to comply with the requirements of subsection (l)(1) of this section.

(p) Severability. If any subsection or portion of a subsection of this section is held to be invalid for any reason, all valid parts are severable from the invalid parts and remain in effect. If any subsection or portion of a subsection 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 section are declared to be severable.

SUBCHAPTER N. SERVICES OF PROCESS

28 TAC § 7.1403

STATUTORY AUTHORITY. The department adopts amendments to §7.1403 under Occupations Code Chapter 953, as added by SB 597; Occupations Code §953.003; Insurance Code §§961.002 - 961.004, as amended by SB 1623; and Insurance Code §36.001.

Occupations Code Chapter 953, as added by SB 597, transferred regulation of for-profit legal services from TDI to the Texas Department of Licensing and Regulation.

Occupations Code §953.003 provides that the acts of marketing, selling, offering for sale, issuing, making, proposing to make, and administering a legal service contract

that is regulated by Occupations Code Chapter 953 are exempt from the Insurance Code and other laws of Texas regulating the business of insurance.

Insurance Code §§961.002 - 961.004, as amended by SB 1623, has nonprofit legal services removed from TDI's regulation.

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

§7.1403. Service on Domestic Insurance Companies Licensed by the State Board of Insurance and on Related Entities Authorized to Conduct Business in Texas.

(a) Person and place for service. Except as provided by subsection (b) and subsection (c) of this section, a domestic insurance carrier, including a casualty, county mutual, farm mutual, fire, fraternal, life, Lloyd's, mutual other than life, reciprocal, stipulated premium, or title insurance company, and any mutual assessment company, carrier providing job protection insurance, risk retention group, third-party administrators (in accordance with Insurance Code Chapter 4151), group hospital service corporation, health maintenance organization, and exempt association under Insurance Code §887.102, authorized to conduct the business of insurance in this state, and any other company domiciled in Texas and engaged in the business of insurance as a principal, may be served with legal process, notice, or demand required or permitted by law by:

(1) serving the president, any active vice-president, secretary, or attorney in fact at the office or principal place of business of that carrier; or

(2) leaving a copy of the process, notice, or demand at the home office or principal business office of the carrier during regular business hours.

(b) Article 1.28 exception. A domestic carrier and the controlling person of the affiliated insurance holding company system that has moved its principal offices and any portion of its books, records, and accounts outside this state under the Insurance Code, Article 1.28, must have appointed the commissioner as their attorney for service for all judicial and administrative processes, notices, or demands.

(c) Domestic purchasing group exception. A domestic purchasing group registered in Texas pursuant to the Insurance Code, Article 21.54, must appoint the commissioner as its agent for service of process and receipt of legal documents.

SUBCHAPTER S. MULTIPLE-EMPLOYER WELFARE ARRANGEMENTS

REQUIREMENTS FOR OBTAINING AND MAINTAINING CERTIFICATE OF AUTHORIZATION

28 TAC § 7.1909

STATUTORY AUTHORITY. The department adopts amendments to §7.1909 under Occupations Code Chapter 953, as added by SB 597; Occupations Code §953.003; Insurance Code §§961.002 - 961.004, as amended by SB 1623; and Insurance Code §36.001.

Occupations Code Chapter 953, as added by SB 597, transferred regulation of for-profit legal services from TDI to the Texas Department of Licensing and Regulation.

Insurance Code §§961.002 - 961.004, as amended by SB 1623, has nonprofit legal services removed from TDI's regulation. TDI proposes to remove the reference to prepaid legal services from §7.1909 to clarify that those plans are not subject to review by TDI.

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

§7.1909. Benefits Allowed to Be Provided by Multiple-Employer Welfare Arrangements.

(a) A multiple-employer welfare arrangement licensed pursuant to the provisions of Insurance Code Chapter 846, and these sections will be limited to providing any one or more of the benefits described in paragraphs (1) - (3) of this subsection, as follows:

(1) medical, dental, optical, surgical, or hospital care;

(2) benefits in the event of sickness, accident, disability, or death; and

(3) any other benefit authorized for health insurers in this state.

(b) A multiple-employer welfare arrangement may only provide benefits to active or retired owners, officers, directors, or employees of or partners in participating employers, or the beneficiaries of such persons, except as may otherwise be limited by provisions of the Employer Retirement Income Security Act of 1974 (29 United States Code §1001 et seq.).

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

Issued at Austin, Texas, on April 5, 2021.

DocuSigned by:
James Person
75578E954EFC48A...

James Person, General Counsel
Texas Department of Insurance

The Commissioner adopts amendments to 28 TAC §§7.25, 7.88, 7.1403, and 7.1909.

Commissioner of Insurance

By: DocuSigned by:
Doug Slape
C77A87C8C21B435...

Doug Slape
Chief Deputy Commissioner
Tex. Gov't Code § 601.002
Commissioner's Order No. 2018-5528