SUBCHAPTER A. Examination and Financial Analysis
28 TAC §7.88

1. INTRODUCTION. The Commissioner of Insurance (Commissioner) adopts new §7.88, concerning independent annual audits of insurer and health maintenance organization (HMO) financial statements. The section is adopted with changes to the proposed text published in the May 28, 2010, issue of the *Texas Register* (35 TexReg 4305).

2. REASONED JUSTIFICATION. New §7.88 is necessary to improve the Department's surveillance of the financial condition of insurers and HMOs by (i) specifying the requirements of an annual audit of the financial statements reporting the financial condition and the results of operations of each insurer or HMO by an independent certified public accountant or accounting firm that meets the requirements of the Insurance Code §401.011 (independent accountant); (ii) requiring communication of internal control related matters noted in an audit; (iii) requiring each insurer or HMO that is required to file an annual audited financial report under the Insurance Code Chapter 401, Subchapter A, to have an audit committee; and (iv) requiring certain insurer or HMO management to prepare and file a report of the insurer's or HMO's or group of insurers' or HMOs' internal control over financial reporting. The phrase *group of insurers or HMOs* is defined in new §7.88(c)(5) as "Those authorized insurers or HMOs included in the reporting requirements of the 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." The Insurance Code Chapter 401, Subchapter A, requires an annual audit by an independent accountant of the financial statements reporting the financial condition and the results of operations of each insurer or HMO, subject to certain specified requirements and exemptions. The provisions of Chapter 401, Subchapter A, are based primarily upon the independent annual audit requirements specified in the *Model Regulation Requiring Annual Audited Financial Reports* (Model Audit Rule or MAR), which was originally adopted by the National Association of Insurance Commissioners (NAIC) in 1980. This new rule is necessary to adopt significant updates to the MAR. These updates were adopted by the NAIC and the American Institute of Certified Public Accountants (AICPA) Working Group in June of 2006. The revised MAR, titled the *Annual Financial Reporting Model Regulation*, incorporates best practice standards and elements of the Sarbanes-Oxley Act of 2002 (SOX) for both non-public and public insurers and HMOs relating to accountant qualifications and independence, corporate governance, and internal control over financial reporting.

The new rule is necessary to adopt these updated standards and requirements in order to (i) improve the Department's surveillance of the financial condition of insurers and HMOs; (ii) clarify, implement, and augment the independent audit requirements of the Insurance Code Chapter 401, Subchapter A; (iii) enable the Department to detect and take appropriate action to address situations in which an insurer or HMO 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 to the policyholders, enrollees, or

creditors of the insurer or HMO or to the public, as contemplated under the Insurance Code Chapters 404, 441, and 843; (iv) ensure the qualifications and independence of the accountant, as contemplated under the Insurance Code §§401.011 - 401.013; and (v) improve corporate governance, internal controls and risk management, which may result in benefits to operating performance, corporate culture, and financial returns. The new requirements are designed to enhance regulatory oversight without undue burden on the insurance industry and to obtain the biggest public benefit at the lowest cost of compliance. As a result, small, medium, and certain large insurers and HMOs (those with less than $500 million in premium) are not subject to some of the new requirements. The new requirements are the end result of several years of continued research, input, discussion, and collaboration by financial regulators, industry members, NAIC staff, public accountants, and trade associations' representatives. Additionally, adoption of the 2006 updates is an NAIC accreditation requirement for each state, effective in calendar year 2010. Therefore, adoption of the 2006 updates is required for the Department to maintain its NAIC accreditation after January 1, 2010. Recent polls of the various state insurance regulators indicate that all fifty states have adopted or plan to adopt substantially similar requirements to the 2006 updates prior to or during calendar year 2010. Therefore, the Department anticipates that insurers and HMOs authorized to conduct business in Texas as well as in another state or states likely will be subject to the substantially similar model audit laws in the other state or states, beginning in calendar year 2010. Moreover, the NAIC/AICPA Working Group, in collaboration with industry representatives, has drafted an implementation guide to help

in the application of and compliance with the new requirements. The implementation guide is an informational appendix to the NAIC Accounting Practices and Procedures Manual (Manual). The Manual with updates is adopted by reference under §7.18 of Title 28 of the Administrative Code, with certain specified exceptions or additions. The implementation guide is expected to reduce the costs and time of implementation by insurers and HMOs subject to the requirements in the new rule.

The effective date for compliance with the new audit committee requirements in §7.88(b)(3) and (n)(1) is changed from the proposed date of August 1, 2010, to September 1, 2010. This change is necessary to provide an applicability date that is subsequent to the effective date of the new rule.

New Requirements Clarify, Implement, and Augment Statutory Requirements

Because the new requirements clarify, implement, and augment the statutory independent audit provisions of the Insurance Code Chapter 401, Subchapter A, it is necessary to read the requirements in new §7.88 in conjunction with the statutory requirements specified in Chapter 401, Subchapter A, and Department rules adopted in Chapters 3, 7, and 11 of Title 28 of the Administrative Code. These Chapters 3, 7, and 11 rules include, but are not limited to, §§3.1501 - 3.1505, 3.1601 - 3.1608, 3.4505(f), 3.6101, 3.6102, 3.7001 – 3.7009, 3.9101 - 3.9106, 3.9401 – 3.9404, 7.7, 7.18, 7.85, and 11.803 (relating, respectively, to Annuity Mortality Tables; Actuarial Opinion and Memorandum Regulation; General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves; Policy Reserves; Claims Reserves; Minimum Reserve Standards for Individual and Group Accident and Health Insurance; 2001 CSO Mortality

Table; Preferred Mortality Tables; Subordinated Indebtedness, Surplus Debentures, Surplus Notes, Premium Income Notes, Bonds, or Debentures, and Other Contingent Evidences of Indebtedness; National Association of Insurance Commissioners Accounting Practices and Procedures Manual; Audited Financial Reports; and Investments, Loans, and Other Assets). For example, §7.85 (relating to Audited Financial Reports) specifically implements the Insurance Code §401.009(d). Section 401.009(d) provides that the Commissioner shall adopt rules governing the information to be included in the audited financial report under the Insurance Code §401.009(a)(3)(H). New §7.88(b)(1) specifies that except as otherwise specified in the Insurance Code Chapter 401, Subchapter A, and in §7.88, the §7.88 requirements apply 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. Chapter 401, Subchapter A, enumerates several exemptions from the various independent audit requirements. Therefore, new §7.88 must be read in conjunction with certain exemptions specified in Chapter 401, Subchapter A, including an exemption provided under §401.006 for certain small insurers or HMOs and an exemption provided under §401.007 for certain foreign or alien insurers or HMOs. Section 401.006(a) provides that an insurer or HMO that has less than $1 million in direct premiums written in this state during a calendar year is exempt from the requirement to file an audited financial report under §401.004 if the insurer or HMO also has less than $1 million in nationwide assumed premiums under

reinsurance agreements during a calendar year and submits an affidavit, made under oath by one of the insurer's or HMO's officers, that specifies the amount of direct premiums written in this state during that period. Section 401.006(b) provides that notwithstanding §401.006(a), the Commissioner may require an insurer or HMO, other than a fraternal benefit society that does not have any direct premiums written in this state for accident and health insurance during a calendar year, to comply with Chapter 401, Subchapter A, if the Commissioner finds that the insurer's or HMO's compliance is necessary for the Commissioner to fulfill the Commissioner's statutory responsibilities. Therefore, an insurer or HMO that has been granted an exemption under the Insurance Code §401.006(a) is also exempt from the independent audit requirements in new §7.88. Also, the Insurance Code §401.007(a) and new §7.88(e)(1) exempt a foreign or alien insurer or HMO that files an audited financial report in another state in accordance with that state's audited financial report requirements from filing the audited financial report under Chapter 401, Subchapter A, if the Commissioner finds that the other state's requirements are substantially similar to the requirements prescribed in Chapter 401, Subchapter A. Therefore, an insurer or HMO that has been granted an exemption under the Insurance Code §401.007(a) and new §7.88(e)(1) is exempt from all of the new §7.88 requirements, except for the new §7.88(e)(1) requirements relating to the submission to the Commissioner of copies of certain filings made in other states. Additionally, for example, the Insurance Code §401.008 provides that an insurer or HMO may apply to the Commissioner for an exemption from compliance with the requirements of Chapter 401, Subchapter A, based upon a finding that compliance

would constitute a severe financial or organizational hardship, except under certain specified circumstances, such as the insurer or HMO being placed under supervision, conservatorship, or receivership during the five-year period preceding the date the application for the exemption is made. An exemption under §401.008 also provides an exemption that extends to the requirements specified in new §7.88. Additionally, for example, new §7.88(f) specifically describes the requirements for the financial statements in the audited financial report, but the new rule does not otherwise specifically address the content of the audited financial report. The Insurance Code §401.009, however, does expressly describe the requirements governing the content of audited financial reports. Moreover, pursuant to §401.009(a)(3)(H) and (d), §7.85 addresses the information that must be included in the audited financial reports in order for the Department to conduct insurer or HMO examinations under the Insurance Code Chapter 401, Subchapter B. Section 7.18 adopts the NAIC Manual as the guideline for statutory accounting principles in Texas to the extent the Manual does not conflict with provisions of the Insurance Code or rules of the Department, including those rules specifically listed in §7.18(a).

The Impact on the Regulator's Financial Condition Examinations

The new requirements are important in identifying insurers' or HMOs' potentially hazardous financial conditions so that corrective actions, if necessary, may be taken by the Department or by the insurers or HMOs at the earliest point in time to alleviate or prevent harm to the public and insurance consumers of this state. The new requirements mandate that certain insurers and HMOs generate, maintain, and report

financial information that is necessary for the Department to conduct the insurer's or HMO's examination under the Insurance Code Chapter 401, Subchapter B. Specifically, new §7.88(m)(1) and (7) require the management of certain insurers or HMOs (i.e., those that have $500 million or more of annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program) to annually prepare and file a management's report of internal control of financial reporting with the Commissioner and to document and make available upon financial condition examination, the basis of management's opinions required under new §7.88(m)(5). The term *internal control over financial reporting* that is required in new §7.88(m)(1) is defined in new §7.88(c)(8) as "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." Additionally, new §7.88(j) requires each insurer or HMO to provide to the Commissioner, not later than the 60th day after the date the annual audit report required by the Insurance Code

Chapter 401, Subchapter A (audited financial report), is filed with the Commissioner, an annual written communication prepared by an independent accountant that describes any unremediated material weaknesses in its internal controls over financial reporting noted during the audit. Also, new §7.88(k)(11) directs the insurer's or HMO's audit committee to require the independent accountant who performs an audit required by the Insurance Code Chapter 401, Subchapter A, and §7.88 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. Further, in accordance with the Insurance Code §401.013(a)(3)(D) and §401.020, an insurer or HMO required to file an audited financial report must require its accountant, who is qualified and independent in accordance with the requirements in the Insurance Code §401.011 and in new §7.88(h), to retain and make available for review by the Department's examiners the independent accountant's work papers and any record of communications between the independent accountant and insurer or HMO relating to the independent accountant's audit that were prepared in conducting the audit. As a result of these new requirements, the Department will have access to insurers' and HMOs' audited financial reporting documentation, including the independent accountant's work papers and related or supporting communications. This access will enable the Department to properly regulate and monitor the financial condition and operations of insurers and HMOs, including any unremediated material weaknesses in their internal control structures. Such unremediated material weaknesses may potentially impair the reliability, accuracy and usefulness of the

financial statements prepared by those insurers and HMOs, filed with the Department, and relied upon by the Department for solvency regulation. More specifically, the Department's receipt of the information required by the new §7.88(g), (j), and (k)(11) requirements will enable the Department to identify those insurers and HMOs that either are: (i) taking timely, appropriate, and reasonable action to address and correct financial problems, including unremediated material weaknesses in their internal controls, or (ii) not taking timely, appropriate, and reasonable action to address these concerns, which may result in a potentially hazardous financial condition. The Department anticipates encouraging insurers and HMOs in the latter category to take action voluntarily to address any financial condition issues, including internal control deficiencies. The Department may require that such action be taken in certain instances when potentially hazardous conditions exist. Thus, the Department anticipates that the information required in new §7.88(g), (j), and (k)(11) will reduce the incidences of future or ongoing financial problems, including unremediated material weaknesses in internal controls, and by extension, will reduce the risk of future insurer and HMO solvency concerns.

Audit Committee Requirements and Management Internal Control Reporting Requirements

Two of the most significant provisions in the new section are the audit committee requirements and the management internal control over financial reporting requirements. Some of the more significant changes relating to these two areas are summarized in this paragraph. New §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), (k), and

(n)(1) address the new audit committee requirements for certain insurers and HMOs that are not completely exempt from the new §7.88 requirements pursuant to the Insurance Code §401.006 or §401.008, or under §401.007 and new §7.88(e)(1). These audit committee requirements are expected to enhance corporate governance and internal controls over financial reporting for the benefit of policyholders, enrollees, creditors, and the public generally. Specifically, new §7.88(c)(3) and (d)(5) require all non-exempt insurers and HMOs to designate a group of individuals to serve as its audit committee, and if such a group is not designated, the insurer's or HMO's entire board of directors constitute the audit committee. New §7.88(d)(5) also provides that the audit committee of an entity that controls an insurer or HMO may, at the election of the controlling person, be deemed to be the insurer's or HMO's audit committee for purposes of §7.88. Section 7.88(b)(3) provides that the specific audit committee requirements in §7.88(k) take effect on September 1, 2010, whereas the due date for filing the management's report of internal control over financial report required under new §7.88(m)(1) will be in calendar year 2011 for the 2010 reporting period. New §7.88(k)(1) exempts the following types of insurers and HMOs from the new audit committee requirements in §7.88(k)(2) and (4) – (12): (i) a foreign or alien insurer or HMO; (ii) an insurer or HMO that is a SOX-compliant entity as defined in new §7.88(c)(13); (iii) an insurer or HMO that is a direct or indirect wholly owned subsidiary of a SOX-compliant entity; and (iv) 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. The NAIC implementation guide explains that the

exception in new §7.88(k)(1) is included in the revised MAR to avoid conflicts between the independence requirements of the revised MAR and those required of public companies under Section 301 of the SOX. The expectation of the Department in including this exception is that the same independent audit committee required of public companies under Section 301 would be deemed to be the insurer's or HMO's audit committee for purposes of this regulation or would participate in the oversight of the insurers or HMOs within the group. Therefore, if material weaknesses, significant deficiencies, and/or significant solvency concerns are identified at the legal entity level, the independent audit committee should be involved in addressing these issues, regardless of their materiality, at the consolidated, parent company level. New §7.88(c)(13) defines a *SOX-compliant entity* as an entity that is required to comply with or voluntarily complies with: (A) the pre-approval requirements provided by 15 U.S.C. Section 78j-1(i); (B) the audit committee independence requirements provided by 15 U.S.C. Section 78j-1(m)(3); and (C) the internal control over financial reporting requirements provided by 15 U.S.C. Section 7262(b) and Item 308, SEC Regulation S-K. New §7.88(k)(2)(A), (5), and (8) require non-exempt insurers or HMOs with over $500 million in direct written and assumed premiums for the preceding calendar year to have a supermajority (75 percent or more) of independent audit committee members. New §7.88(k)(2)(B), (5), and (8) require non-exempt insurers or HMOs with $300 million to $500 million in direct written and assumed premiums for the preceding calendar year to have a majority (50 percent or more) of independent audit committee members. Whether any audit committee member is "independent" for purposes of §7.88(k) is a

case-by-case, fact-specific determination, and depends generally on whether, under §7.88(k)(8), an audit committee member (i) other than in his or her capacity as a member of the audit committee, the board of directors, or any other board committee, accepts any consulting, advisory, or other compensatory fee from the entity; or (ii) is an affiliate of the entity or an affiliate of any subsidiary of the entity. New §7.88(k)(2)(C) and (5) provide that except as provided in §7.88(k)(3), a non-exempt insurer or HMO with less than $300 million in direct and assumed premiums for the preceding calendar year is not required to comply with the §7.88(k)(2) independence requirements for its audit committees. The insurers and HMOs subject to the §7.88(k)(3) requirement are those insurers and HMOs for which the Commissioner requires the insurer's or HMO's board to enact improvements to the independence of the audit committee membership if the insurer or HMO (i) is in a risk-based capital action level event; (ii) meets one or more of the standards of an insurer or HMO considered to be in hazardous financial condition; or (iii) otherwise exhibits qualities of a troubled insurer or HMO. New §7.88(k)(4) authorizes an insurer or HMO with less than $500 million in direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Corporation, to apply to the Commissioner for a hardship waiver from the independence requirements of new §7.88(k)(1), (2), and (5) – (12). New §7.88(k)(5) provides that the terminology "direct written and assumed premiums for the preceding calendar year" when used in subsection (k) of §7.88 means the combined total of direct premiums and assumed premiums from non-affiliates for the reporting entities. New §7.88(k)(6) provides that

the audit committee of the insurer or HMO is directly responsible for the appointment, compensation, and oversight of the work of any independent accountant and that each independent accountant shall report directly to the audit committee. New §7.88(k)(7) requires that each member of the audit committee be a member of the board of directors of the insurer or HMO or a member of the board or directors of an entity elected under new §7.88(k)(10) and described under new §7.88(c)(3). New §7.88(k)(6), (11), and (12) require each independent accountant to report certain specified information directly to the audit committee. New §7.88(k)(10), in conjunction with new §7.88(c)(3), provides that 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.

New §7.88(m)(1) requires certain large insurers or HMOs required to file an audited financial report under the Insurance Code Chapter 401, Subchapter A, and new §7.88 to prepare an annual management report of the insurer's or HMO's internal control over financial reporting and submit that report annually to the Commissioner. The insurers and HMOs subject to new §7.88(m)(1) have $500 million or more in annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, and have not been granted an exemption under §401.006 or §401.008, or under §401.007 and new §7.88(e)(1). New §7.88(m)(3) and (4) allows, under certain specified conditions, an insurer or HMO or a group of insurers or HMOs to file with the Commissioner the insurer's or HMO's or the insurer's or HMO's parent's Section 404 report, as that term is

defined in new §7.88(c)(11), and an addendum, as described in new §7.88(m)(4), 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. The Section 404 report is required by Section 404 of the SOX. The conditions specified in new §7.88(m)(4) are: (i) a Section 404 report 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 specified in the Insurance Code §401.009(a)(3)(B) – (H) and (b); and (ii) the addendum required to be filed under new §7.88(m)(3) must be a positive statement 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 the Insurance Code §401.009(a)(3)(B) – (H) and (b). New §7.88(m)(4) further requires that 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 management report under §7.88(m)(1) or the Section 404 report and a report under §7.88(m)(1) 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. New §7.88(m)(5) – (8) specifies management's responsibilities for internal control over financial reporting. New §7.88(m)(7) requires the management of an insurer or HMO to document and make available upon financial condition examination, the basis of the opinions required by §7.88(m)(5). These internal controls over financial reporting requirements provide the Department with additional assurances of the effectiveness of an insurer's or HMO's internal control practices in a cost effective manner. Management's assertions about the effectiveness of the company's internal controls over financial reporting enhance oversight and understanding of insurer and HMO solvency by enabling the Department to have greater confidence in the accuracy and reliability of financial reporting. This, in turn, benefits policyholders, enrollees, creditors, and the public generally. An additional expected benefit of this enhancement, where internal controls over financial reporting are effective, is that financial examinations will become more efficient and risk-focused. Additionally, similar to SOX Section 404, the new requirements prohibit management from determining that internal controls over financial reporting are effective if one or more un-remediated material weaknesses exist as of the balance sheet date. Unlike SOX Section 404, new §7.88(m) does not require that an insurer's or HMO's independent accountant provide an attestation report on the effectiveness of internal controls over financial reporting.

New Lead Audit Partner Limitation

New §7.88(h) specifies the accountant qualifications and independence

standards and requirements relating to the Commissioner's acceptance of audited financial reports from an independent accountant. New §7.88(h)(1) provides certain limitations on the number of years that an audit partner may serve in the capacity of lead audit partner or other person responsible for rendering an audited financial report for an insurer or HMO. Under §7.88(b)(2), these limitations go into 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. These limitations are modeled after and consistent with the limitations in the revised NAIC Model Rule. Under the Insurance Code §401.011(c), a partner or other person responsible for rendering an audit report for an insurer or HMO for seven consecutive years may not, during the two-year period after that seventh year, render an audit 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. Section 401.011(c) further provides that the Commissioner may determine that this limitation does not apply to an accountant for a particular insurer or health maintenance organization if the insurer or HMO demonstrates to the satisfaction of the Commissioner that the application of the limitation to the insurer or HMO would be unfair because of unusual circumstances. In making the determination, the Commissioner may consider: (i) 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; (ii) the premium volume of the insurer or health maintenance organization; and (iii) the number of jurisdictions in which the insurer or HMO engages

in business. Under new §7.88(h)(1), the lead audit 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 following that fifth year, render a 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 unless the insurer or HMO requests an exemption. Under new §7.88(h)(1), the insurer or HMO may submit a written application to the Commissioner at least 30 days before the end of the calendar year for an exemption from the new §7.88(h)(1) accountant qualifications and independence requirement. The Commissioner may determine that the limitation does not apply for a particular insurer or HMO if the insurer or HMO demonstrates to the satisfaction of the Commissioner that the application of the limitation to the insurer or HMO would be unfair because of unusual circumstances. In making the determination, the Commissioner may consider: (i) 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; (ii) the premium volume of the insurer or HMO; and (iii) the number of jurisdictions in which the insurer or HMO engages in business. The five-year limitation under new §7.88(h)(1) is necessary for the following reasons. First, it is part of the 2006 updates necessary for the Department to maintain its NAIC accreditation after January 1, 2010. The provisions of the Insurance Code Chapter 401, Subchapter A, including §401.011(c) that specifies the seven-year limitation for a partner or other person responsible for rendering an audited financial report for an insurer or HMO, are based primarily upon the independent annual

audit requirements specified in the MAR, which was originally adopted by the NAIC in 1980. Significant updates to the MAR, including the five-year limitation for independent accountants in §7.88(h)(1), were adopted by the NAIC and the AICPA Working Group in June of 2006. The revised MAR incorporates best practice standards and elements of SOX for both non-public and public insurers and HMOs relating to accountant qualifications and independence, corporate governance, and internal control over financial reporting. The five-year limitation in §7.88(h)(1) is consistent with the new rotation limitation prescribed under the NAIC's revised MAR, which is to be effective beginning with audits of the 2010 financial statements and is expected to be substantially adopted by other states prior to or during calendar year 2010. Thus, insurers and HMOs that are licensed or authorized to conduct the business of insurance in another state will be expected to meet the five-year limitation in calendar year 2010 in order to comply with the other state's laws. Second, it is necessary to effectuate the accountant independence requirements in the Insurance Code §§401.011 – 401.014. Pursuant to §§401.011 - 401.014, the Commissioner has the responsibility to ensure the independence and qualifications of accountants engaged by insurers and HMOs to prepare the statutorily required annual audited financial reports. The Department anticipates a number of benefits will result from increasing the independent accountant rotation frequency, including, but not limited to, that a lead auditor partner will (i) be less prone to become overly comfortable with an insurer's or HMO's methods of operations, internal controls and accounting systems, thereby decreasing the risk that the independent accountant will place unwarranted reliance on the accuracy of the insurer's

or HMO's financial reports; (ii) be less prone to become overly comfortable with the insurer's or HMO's staff, officers and directors, thereby decreasing the risk that the lead audit partner will fail to exhibit appropriate impartiality or independent judgment, and/or adequately question and investigate the veracity of representations made to the lead audit partner during the course of the audit; and (iii) be more likely to exhibit a tendency to ask probing questions that ultimately relate to the reliability of the insurer's or HMO's accounting systems and internal controls and the accuracy of the insurer's or HMO's reported financial condition. Accordingly, the limitation will help to ensure the independence of the lead audit partner from the insurer or HMO being audited. Third, the limitation under new §7.88(h)(1) is necessary to implement and/or supplement several financial solvency regulatory statutes, including the Insurance Code (i) §32.041, concerning statement blanks and other reporting forms necessary for companies to comply with the filing requirements; (ii) Chapters 404 and 843, concerning an insurer's or HMO's hazardous financial condition; (iii) Chapters 441 and 843, concerning the rehabilitation and conservation of insurers and HMOs; (iv) §421.001, concerning the adoption of each current NAIC formula for establishing reserves applicable to each line of insurance; and (v) §§802.001 - 802.003 and 802.051 - 802.056, concerning the Commissioner's authority to make changes in the forms of the annual statements required of insurance companies of any kind, as necessary to obtain an accurate indication of the company's condition and method of transacting business, and to require certain insurers to make filings with the NAIC. Fourth, the Commissioner is required to protect insureds, enrollees or creditors, and the public against an insurer or

HMO becoming insolvent, delinquent, or in a condition that renders the continuance of its business hazardous to its insureds, enrollees or creditors, or to the public, as contemplated under Chapters 404, 441, and 843. New §7.88(h)(1) provides an important tool for the Commissioner to accomplish this responsibility. The increased minimum rotation of lead audit partners will result in improvements in the qualifications and independence of the lead audit partner, which the Department believes will result in financial books and records, financial statements, and audited financial reports that are more likely to be complete, current, reliable, and reflect the true and correct financial condition and operational results of the insurer or HMO being audited. An accountant that is more highly qualified and truly independent will be more likely to conclude in an audited financial report, when appropriate, that an insurer or HMO is operating in a hazardous financial condition as compared to an accountant that is less qualified and independent. Conversely, allowing a lead audit partner to be less qualified or independent, or allowing a lead audit partner that has a potential conflict of interest, will increase the risk that the accountant will give a clean audited financial report in circumstances where a clean audited financial report is not appropriate, or will understate the severity of issues found during the audit, for insurers or HMOs that may be operating in a hazardous financial conditions. The Commissioner relies on the audited financial report and the accountant's opinion in monitoring and regulating the insurer's or HMO's financial position and operations. Thus, it is crucial that the accountant be completely independent from the insurer or HMO in expressing an opinion on the financial statement in an audited financial report filed under Chapter 401,

Subchapter A. New §7.88(h)(1) will help to ensure this independence and impartiality, and therefore, enhance the ability of the Department to actively monitor and regulate the financial condition and operations of insurers and HMOs. Therefore, although new §7.88(h)(1) provides a more restrictive limitation on lead audit partners than the statutory limitation specified in §401.011(c), the five-year limitation is not only necessary, as previously explained, to update the obsolete seven-year limitation in §401.011(c) in order to bring the Department into consistency with the updated revised NAIC MAR so that the Department may maintain its NAIC accreditation after January 1, 2010, it is also necessary to more effectively implement the purpose of §401.011(c) of the Insurance Code. Therefore, the two limitations can be harmonized. Both new §7.88(h)(1) and existing §401.011(c) serve to ensure the independence of accountants to thereby protect against insurer or HMO insolvencies. Both are necessary for consistency with the revised NAIC MAR at the time of their implementation by the Department. Significantly, both also allow insurers and HMOs to petition the Commissioner to authorize another alternative limitation if the requisite criteria are met. This includes petition under new §7.88(h)(1) to use the seven-year limitation in §401.011(c). The §7.88(h)(1) criteria for the Commissioner to make such an authorization are the same as the criteria specified in §401.011(c). This ability of the insurers and HMOs to petition for an exemption from the §7.88(h)(1) limitation reflects the intent of the Commissioner to accept, consider, and grant such petitions when the requisite criteria are met. This intent is further supported by the fact that the criteria for the Commissioner’s determination are the same criteria as the existing statutory criteria

for the Commissioner's determination that an alternative to the seven-year limitation should be granted.

History of the Proposal

On September 16, 2009, the Department posted a draft rule for informal comment, concerning requirements for annual independent audits of insurer and HMO financial statements and insurer and HMO internal controls. The informal comment period ended on September 30, 2009. The Department held a meeting on October 1, 2009, for stakeholder comments. On May 14, 2010, the Department filed the proposed rule for publication in the *Texas Register* for comment. The proposed rule was published in the May 28, 2010, issue of the *Texas Register* (35 TexReg 4305). On June 24, 2010, the Department held a public hearing for public input and comment. The proposal comment period ended on June 28, 2010.

Changes to the Proposal

In response to comments received on the published proposal, the Department has revised §7.88(k)(8) and (n) as proposed. The Department has also made non-substantive clarification changes to §7.88(h)(10) and (m)(8) as proposed. Additionally, the Department has made a clarification change to §7.88(k)(8) as proposed that is in addition to the clarification changes made in response to comments. In addition, as previously discussed, the Department has revised §7.88(b)(3) and (n)(1) as proposed to change the effective date for compliance with the new audit committee requirements from August 1, 2010 to September 1, 2010. However, none of these changes materially alter issues raised in the proposal, introduce new subject matter, or affect persons other

than those previously on notice.

The following changes are made to the proposed text. The Department made a non-substantive change to new §7.88(k)(8) to replace the term “affiliated person” with the term “affiliate,” which is defined in §7.88(c)(2). The Department made another non-substantive change to new §7.88(k)(8) to add the words “an affiliate of” before the phrase “any subsidiary of the entity.” These changes are made in response to a commenter asking what the term “affiliated person” in proposed §7.88(k)(8) means. The changes are necessary for clarification and to remove ambiguity about the meaning of the terms “independent” and “affiliate” in §7.88(k)(8) as adopted. Additionally, §7.88(k)(8) as proposed is revised to change the term “person’s” to “his or her” to clarify that only a natural person is referenced in this particular part of the provision. Proposed §7.88(k)(8) as adopted reads “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.” (italics indicates revised language)

New §7.88(n)(2) is added in response to comments from several Medicaid and CHIP HMOs that asked for clarification of the transition period in proposed §7.88(n)(2)

and that raised concerns with the cost of complying with the requirement in §7.88(m) to prepare and file a management's report of internal control over financial reporting. As adopted, §7.88(n) contains a new paragraph (2) and proposed paragraph (2) is re-designated as paragraph (3) with one nonsubstantive change to the proposed text. Section 7.88(n)(2) as adopted provides that "An insurer or HMO required to file an audited financial report under the 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 periods must comply with the reporting requirements in subsection (m) 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." The addition of new §7.88(n)(2) is necessary to clarify the transition period for compliance with §7.88(m) so that insurers and HMOs that reach the required $500 million premium transition threshold for the first time for the reporting period ending December 31, 2010, will have a two-year transition period. In the second sentence of §7.88(n)(3) as adopted, the word "required" is added between the word "amount" and the phrase "to file a report" for purposes of clarification. Section 7.88(n)(3) as adopted provides, in pertinent part, that "An insurer or HMO or group of insurers or HMOs that is not required by subsection (m)(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**.**" (italics indicates revised language)

Section 7.88(h)(10) as proposed is revised to change the term "person" to "individual" to clarify that only a natural person is referenced in this provision. Section 7.88(h)(10) as adopted reads in pertinent part: "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." (italics indicates revised language)

Section 7.88(m)(8) as proposed is revised to change the phrase "as to" to "about" for purposes of proper grammar. Section 7.88(m)(8) as adopted reads: (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." (italics indicates revised language)

3. HOW THE SECTION WILL FUNCTION.

§7.88(a). Purpose. Section 7.88(a) states the purpose of the new section.

§7.88(b). Applicability. Section 7.88(b) sets forth the applicability of the new section. Section 7.88(b)(1) specifies that except as otherwise specified in that section and in the 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. Section 7.88(b)(2) specifies that the lead audit partner independence requirements in §7.88(h)(1) are 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. Under §7.88(b)(3), the audit committee requirements in §7.88(k) take effect September 1, 2010.

§7.88(c). Definitions. Section 7.88(c) specifies definitions of certain terms or phrases when used in the section, including the terms or phrases "*accountant*, *affiliate*, *audit committee*, *group of insurers or HMOs*, *insurer, Section 404*, and *Section 404 report*. Section 7.88(c)(7) defines the term "insurer" to explain which insurers, in addition to HMOs, are subject to the new requirements in this adoption. These insurers are any insurer authorized to engage in business in this state, including: (i) a life, health, or accident insurance company; (ii) a fire and marine insurance company; (iii) a general casualty company; (iv) a title insurance company; (v) a fraternal benefit society; (vi) a mutual life insurance company; (vii) a local mutual aid association; (viii) a statewide mutual assessment company; (ix) a mutual insurance company other than

a mutual life insurance company; (x) a farm mutual insurance company; (K) a county mutual insurance company; (xi) a Lloyd's plan; (xii) a reciprocal or interinsurance exchange; (xiii) a group hospital service corporation; (xiv) a stipulated premium company; and (xv) a nonprofit legal services corporation. The term “accountant” in this section refers to an independent certified public accountant or accounting firm that meets the requirements of the Insurance Code §401.011. Section 7.88(c)(2) defines the term “affiliate” as having the meaning assigned by the Insurance Code §823.003. Section 7.88(c)(3) defines the term “audit committee” and specifies certain circumstances that affect the constitution or designation of the audit committee. The term “audit committee” means a committee established by the board of directors of an insurer or HMO for the purpose of overseeing (i) the accounting and financial reporting processes of an insurer or HMO or group of insurers or HMOs; and (ii) the audits of financial statements of the insurer or HMO or group of insurers or HMOs. The definition further provides that 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 §7.88. Also, under the definition, 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. Section 7.88(c)(5) defines the phrase “group of insurers or HMOs” as “Those authorized insurers or HMOs included in the reporting requirements of the 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.” Section

7.88(c)(11) defines the term “Section 404” as “Section 404, Sarbanes-Oxley Act of 2002 (15 U.S.C. Section 7262), and rules adopted under that section.” Section 7.88(c)(12) defines the phrase “Section 404 report” as “Management's report on internal control over financial reporting as determined by the SEC and the related attestation report of an accountant.”

§7.88(d). Filing and Extensions for Filing of Audited Financial Report. Section 7.88(d)(1) – (4) sets out requirements for filing the annual audited financial reports, including a requirement that insurers and HMOs file the audited financial reports with the Commissioner on or before June 1 for the preceding calendar year, except as otherwise provided. This requirement is a change from the current requirement of filing on or before June 30. Thus, insurers and HMOs will need to file their audited financial reports for calendar year 2010 on or before June 1, 2011, unless otherwise provided under the new section. Section 7.88(d)(5) requires an insurer or HMO required to file an annual audited financial report under the Insurance Code Chapter 401, Subchapter A and the new section to designate a group of individuals to serve as its audit committee. Section 7.88(d)(5) further provides that 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 §7.88.

§7.88(e). Exemption for Certain Foreign or Alien Insurers or HMOs. Section 7.88(e)(1) sets forth certain filing requirements for foreign or alien insurers or HMOs found by the Commissioner to meet the exemption provisions in the Insurance Code §401.007. Section 7.88(e)(2) specifies that 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 §7.88(m)(1) if the other state has substantially similar reporting requirements and the report is filed with the commissioner in that state in the time specified.

§7.88(f). Requirements for Financial Statements in Audited Financial Report. Section 7.88(f) specifies certain requirements for financial statements included in the audited financial report.

§7.88(g). Scope of Audit and Report of Accountant. Section 7.88(g) sets forth the scope of the annual audited financial report, which includes certain new requirements related to internal control over financial reporting.

§7.88(h). Qualifications and Independence of Accountant; Acceptance of Audited Financial Report. Section 7.88(h) specifies the accountant qualifications and independence standards and requirements of the audited financial report from an independent accountant that is required to be filed with the Commissioner. Section 7.88(h)(1) provides certain limitations on the number of years that an audit partner may serve in the capacity of lead audit partner or other person responsible for rendering an audited financial report for an insurer or HMO. These limitations are modeled after and consistent with the limitations in the revised NAIC Model Audit Rule. Under current requirements, the lead audit partner is permitted to serve for seven consecutive years in that capacity with a mandatory two-year break in service before being eligible to serve another seven consecutive years. Under the revised requirements in §7.88(h)(1), the lead audit partner (or other person having primary responsibility for the audit) may not

act in that capacity for more than five consecutive years followed by a five-year break in service before being eligible to serve another five consecutive years. An insurer or HMO, however, may apply to the Commissioner for an exemption from this new limitation. The insurer or HMO may submit a written application to the Commissioner at least 30 days before the end of the calendar year for exemption from the limitation. Based on a specified list of factors that may be considered by the Commissioner, the Commissioner may determine that the §7.88(h)(1) limitation requirement 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. Under §7.88(h)(2), an insurer or HMO for which the Commissioner has approved an exemption under §7.88(h)(1) is required to file the approval with the states in which it is doing or is authorized to do business and with the NAIC. Pursuant to §7.88(h)(3), an accountant that provides audit services to an insurer or HMO is prohibited from functioning in the role of management, auditing the accountant's own work, or serving in an advocacy role for the insurer or HMO; or directly or indirectly entering into an agreement of indemnity or release from liability regarding the audit of the insurer or HMO. The Commissioner pursuant to §7.88(h)(4) 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 certain specified non-audit services that, if performed by the accountant, would impact the accountant’s independence in relation to the insurer or HMO, subject to the exemption specified in §7.88(h)(6).

Section 7.88(h)(5) provides that notwithstanding §7.88(4)(D), an independent accountant and the independent accountant's actuary, under certain specified conditions, may provide certain actuarially oriented advisory services involving the determination of amounts recorded in the financial statements. Section 7.88(h)(6) allows certain insurers and HMOs with direct written and assumed premiums of less than $100 million in any calendar year to apply for an exemption to the §7.88(h)(4) prohibitions relating to the types of services or functions that the independent accountant is not allowed to provide to the insurer or HMO. Such insurers and HMOs may request an exemption from the requirements of §7.88(h)(4) by filing with the Commissioner a written statement explaining why the insurer or HMO should be exempt. Under §7.88(h)(6), the Commissioner may grant the exemption if the Commissioner finds that compliance would impose an undue financial or organizational hardship on the insurer or HMO. Section 7.88(h)(7) – (9) requires pre-approval by the audit committee of all auditing and non-audit services performed by the accountant, except as otherwise provided under §7.88(h)(7) – (9). The Commissioner pursuant to §7.88(h)(10) 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 other person serving in an equivalent position for the insurer or HMO was employed by the accountant and participated in the audit of the insurer or HMO within the one-year prior to the due date of the most current statutory opinion. Also, under §7.88(h)(10), an insurer or HMO may apply to the Commissioner for an exemption from the requirements

of §7.88(h)(10) on the basis of unusual circumstances. The Commissioner pursuant to §7.88(h)(11) shall not accept an audited financial report prepared wholly or partially by an individual or firm who the Commissioner finds: (i) has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act (18 U.S.C. Section 1961 et seq.), or a state or federal criminal offense involving dishonest conduct; (ii) has violated the insurance laws of this state with respect to a report filed under the Insurance Code Chapter 401, Subchapter A, or this section; (iii) has demonstrated a pattern or practice of failing to detect or disclose material information in reports filed under the Insurance Code Chapter 401, Subchapter A, or §7.88; or (iv) has directly or indirectly entered into an agreement of indemnity or release of liability regarding an audit of an insurer. Under §7.88(h)(12), the insurer or HMO must file, with its annual statement filing, the approval of an exemption granted under §7.88(h)(6) or (10) with the states in which it does or is authorized to do business and with the NAIC. An insurer or HMO must comply with the independent accountant registration requirements in the Insurance Code §401.014 in addition to the independent accountant requirements specified in §7.88(h).

§7.88(i) Accountant's Letter of Qualifications. Section 7.88(i) requires that the audited financial report required under the Insurance Code §401.004 be accompanied by a letter, provided by the accountant who performed the audit, that includes the representations and statements required under the Insurance Code §401.013, and a representation that the accountant is in compliance with the requirements specified in §7.88(h).

§7.88(j) Communication of Internal Control Matters Noted in Audit. Under §7.88(j), each insurer or HMO is required to provide to the Commissioner, not later than the 60th day after the date the audited financial report is filed, an annual written communication prepared by an accountant that describes any unremediated material weaknesses in its internal controls over financial reporting noted during the audit. Also, under §7.88(j) each insurer or HMO must provide the Commissioner with a description of remedial actions taken, or proposed, to correct unremediated material weaknesses if these actions are not described in the accountant's communication.

§7.88(k). Requirements for Audit Committees. Section 7.88(k), in conjunction with §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), and (n)(1), addresses the audit committee requirements for certain insurers or HMOs that are not completely exempt from the §7.88 requirements pursuant to the Insurance Code §401.006 or §401.008, or under §401.007 and §7.88(e)(1). As previously explained, §7.88(c)(3) defines the term "audit committee" as a committee established by the board of directors of an entity for the purpose of overseeing (i) the accounting and financial reporting processes of an insurer or HMO or group of insurers or HMOs; and (ii) the audits of financial statements of the insurer or HMO or group of insurers or HMOs. Under §7.88(c)(3), (d)(5), and (h)(7) – (9), all non-exempt insurers or HMOs are required to have an audit committee charged with the appointment, compensation, and supervision of the insurer or HMO's independent accountant. If a non-exempt insurer or HMO does not designate an audit committee, then §7.88(b)(3) provides that the non-exempt insurer or HMO's entire board of directors shall constitute the audit committee. Section 7.88(k)(1) exempts the

following types of insurers and HMOs from the §7.88(k)(2) and (4) – (12) audit committee requirements: (i) a foreign or alien insurer or HMO; (ii) an insurer or HMO that is a SOX-compliant entity as defined in §7.88(c)(13); (iii) an insurer or HMO that is a direct or indirect wholly owned subsidiary of a SOX-compliant entity; or (iv) 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. Section 7.88(k)(2) and (3) address the independence requirements for audit committee membership. Under §7.88(k)(2)(B), non-exempt insurers or HMOs with $300 million to $500 million in preceding calendar year direct written and assumed premiums must have a majority (50 percent or more) of audit committee members that are independent. Under §7.88(k)(2)(A), non-exempt insurers or HMOs with over $500 million of preceding calendar year direct written and assumed premiums must have a supermajority (75 percent or more) of audit committee members that are independent. Section 7.88(k)(2)(C) provides that except as provided in §7.88(k)(3), a non-exempt insurer or HMO with less than $300 million in direct and assumed premiums for the preceding calendar year is not required to comply with the §7.88(k)(2) independence requirements for its audit committee members. The insurers or HMOs subject to the §7.88(k)(3) requirement are those insurers and HMOs for which the Commissioner requires an insurer's or HMO's board to enact improvements to the independence of its audit committee membership if the insurer or HMO meets certain specified circumstances. Under §7.88(k)(4), an insurer or HMO with less than $500 million in direct written and assumed premiums (subject to certain exclusions in determining the amount of direct

written and assumed premiums specified in §7.88(k)(4) and (5)) may apply to the Commissioner for a hardship waiver from the independence requirements of §7.88(k)(1), (2), and (5) – (12). Section 7.88(k)(5) provides that in §7.88(k), direct written and assumed premiums for the preceding calendar year shall be the combined total of direct premiums and assumed premiums from non-affiliates for the reporting entities. Section 7.88(k)(6) specifies certain responsibilities of insurer or HMO audit committees that relate to the independent accountant for the non-exempt insurer or HMO. Section 7.88(k)(7) requires each member of the audit committee to 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 §7.88(k)(10). Section 7.88(k)(8) specifies what constitutes “independence” for a member of the audit committee for purposes of §7.88(k). Pursuant to §7.88(k)(9), if an audit committee member ceases to be independent for reasons outside the member’s reasonable control, the member may remain an audit committee member until the earlier of: (i) the next annual meeting of the responsible entity; or (ii) the first anniversary of the occurrence of the event that caused the member to be no longer independent. The responsible entity, however, must provide notice to the Commissioner as specified in §7.88(k)(9)(A) and (B). Section 7.88(k)(10), in conjunction with §7.88(c)(3) and (k)(7), describes the process for the controlling person to exercise its election to designate an audit committee of an entity that controls an insurer or HMO solely for purposes of §7.88. Section 7.88(k)(11) and (12) specify independent accountant reporting requirements to the audit committee.

Under §7.88(b)(3), the audit committee requirements in §7.88(k) take effect September 1, 2010.

§7.88(l). Prohibited Conduct in Connection with Preparation of Required Reports and Documents. Section 7.88(l) specifies prohibited conduct in connection with preparation of required reports and documents. Section 7.88(l) prohibits directors or officers of an insurer or HMO from making materially false or misleading statements, or omitting material facts in statements made to independent accountants in connection with an audit, review, or communication required by the Insurance Code, Chapter 401, Subchapter A, or the new section.

§7.88(m). Report of Internal Control over Financial Reporting. Section 7.88(m)(1) requires an insurer or HMO with greater than $500 million in direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, to prepare and file a management report of internal control over financial reporting with the Commissioner, unless the insurer or HMO meets an exemption provided under §401.006 or §401.008, or under §401.007 and §7.88(e)(2). Pursuant to §7.88(m)(2), the Commissioner may require an insurer or HMO regardless of the amount of the annual direct written and assumed premiums 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 statutory hazardous financial condition standards. The requirements and process for preparing and filing the management report are specified in detail in §7.88(m)(1) – (8). Section 7.88(m)(3) and (4) specify certain options for complying with the management report requirements in

§7.88(m)(1) or (2) for certain insurers or HMOs or a group of insurers or HMOs that file the insurer's or HMO's or the insurer's or HMO's parent's Section 404 report and an addendum with the Commissioner.

§7.88(n). Transition Dates. Section 7.88(n)(1) sets forth certain transition dates for certain insurers or HMOs whose audit committee as of September 1, 2010, is not subject to the independence requirements of §7.88(k)(2)(A) or (B) because the total premium is below the threshold specified in that subsection, and that later becomes subject to one of the independence requirements because of increases in the amount of premium. Under §7.88(n)(2), an insurer or HMO that reaches the $500 million premium transition threshold for the first time for the reporting period ending December 31, 2010, may have a two-year transition period after the year in which the written premium exceeds the threshold amount required to file a report in compliance with §7.88(m). Section 7.88(n)(3) requires an insurer or HMO or group of insurers or HMOs that is not required by §7.88(m)(1) to file a report beginning with the reporting period ending December 31, 2010, because the total written premium is below the required threshold amount, to file a report no later than two years after the year in which the written premium exceeds the required threshold amount to file a report.

§7.88(o). Severability. Section 7.88(o) sets forth the severability provisions for the new section.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General Comment

Comment: One commenter supports the proposed rule published in the *Texas Register* and commends the Department's efforts in adopting the rule.

Agency Response: The Department appreciates the comment.

§7.88(d)(1) – (4). Extension for Filing Audited Financial Report.

Comment: One commenter inquires whether there is a mechanism by which a company that is a Texas only company and has an affiliate company that is licensed in more than one state can delay their filing of the audited financial report to June 30th.

Agency Response: An insurer or HMO required to file an audited financial report with the Commissioner under the Insurance Code, Chapter 401, Subchapter A, may request an extension of the filing date in accordance with the Insurance Code §401.004(c). Section 7.88(d)(4) provides that the Commissioner may grant an extension of the filing date for the audited financial report in accordance with the Insurance Code §401.004(c). Under §401.004(c), an insurer or HMO may request an extension of the filing date by submitting the request in writing before the 10th day preceding the filing date and including sufficient detail for the Commissioner to make an informed decision on the requested extension. Section 401.004(c) authorizes the Commissioner to grant a written extension request for good cause based on a showing by the insurer or HMO or the insurer's or HMO's accountant of the reasons for requesting the extension. Therefore, an insurer or HMO required to file an audited financial report with the Commissioner under the Insurance Code, Chapter 401, Subchapter A, has the option of either complying with the June 1 filing date in

§7.88(d)(1) or seeking an extension of the filing date under §7.88(d)(4) and §401.004(c). The Department's response relates to the Department's filing requirements only. Companies that do business in other states should check with those other states to determine the date that audited financial reports are required to be filed in those other states.

§7.88(c)(3) and (k). Audit Committee Requirements.

Comment: One commenter asks if under proposed §7.88(c)(3) and (k)(7), the default provision is for the insurer's or HMO's entire board of directors to constitute the audit committee if an audit committee is not otherwise selected, then what happens to the independent audit committee member requirement where there are not outside directors on the board of directors.

Agency Response: The audit committee member independence requirements in §7.88(k)(2), relating to the establishment of an audit committee by an insurer or HMO with over $500 million in direct written and assumed premiums for the preceding calendar year and by an insurer or HMO with $300 million to $500 million in direct written and assumed premiums for the preceding calendar and in §7.88(k)(3), relating to the insurer's or HMO's board being required by the Commissioner to enact improvements to the independence of the audit committee membership under certain adverse financial condition circumstances, are distinct and independent requirements from the requirements in §7.88(c)(3) and (k)(7). Section 7.88(c)(3) defines the term "audit committee" as "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.*" [emphasis added] Section 7.88(k)(7) requires each member of the audit committee to 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 §7.88(k)(10) and described under §7.88(c)(3). Because these are separate and independent requirements from the audit committee member independence requirements in §7.88(k)(2) or (3), insurers and HMOs are required to take all necessary steps to comply with the independence requirements in §7.88(k)(2) or (3), as applicable, regardless of whether the audit committee provisions in §7.88(c)(3) and (k)(7) are also applicable to a specific insurer or HMO.

Comment: One commenter asks what the term "affiliated person" means in proposed §7.88(k)(8). This commenter further inquires whether the following parties can be "independent" for purposes of being a director/audit committee member under proposed §7.88(k)(8): (i) An equity owner if that owner receives dividends on the

stocks owned; (ii) shareholders of 10 percent or greater; (iii) shareholders of less than 10 percent; (iv) any shareholder of preferred stock that pays a dividend; and (v) any policyholder or member that gets paid a dividend.

Agency Response: As a result of the commenter's question about the meaning of the term "affiliated person" in proposed §7.88(k)(8), the Department for purposes of clarification has replaced in §7.88(k)(8) as adopted the term "affiliated person" with "affiliate", replaced the word "person's" with "his or her" and added the words "an affiliate of" before the phrase "any subsidiary of the entity." Proposed §7.88(k)(8) as adopted reads in pertinent part: "To be independent for purposes of this subsection, a member of the audit committee may not, other than in the 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." Whether an equity owner, policyholder, or member of an insurer or HMO, is "independent" for purposes of §7.88(k) is a case-by-case, fact-specific determination, and depends generally on whether, under §7.88(k)(8), an audit committee member (i) other than in his or her capacity as a member of the audit committee, the board of directors or any other board committee, accepts any consulting, advisory, or other compensatory fee from the entity; or (ii) is an affiliate of the entity or an affiliate of any subsidiary of the entity. Section §7.88(c)(2) defines the term "affiliate" as used in §7.88 as having the meaning assigned by the Insurance Code §823.003. Section 7.88(c)(2) is modeled after and consistent with the Insurance Code §401.001(2) and Section 3B of the NAIC Model Audit

Regulation. Under §823.003(a) of the Insurance Code, a person is an affiliate of another if the person directly or indirectly through one or more intermediaries controls, is controlled by, or is under common control with the other person. In general, an equity owner that directly or indirectly owns more than 10 percent of the voting securities or authority of an entity is presumed to be an affiliate of the entity. Also, a person may be considered an affiliate of an entity as the result of another basis for determining that an affiliate relationship with the entity exists. For example, a person may (i) own less than 10 percent of the voting securities or authority of an entity, and (ii) also have a management contract and power of attorney that gives the person the power to direct the management and policies of the entity. In this example, an affiliate relationship generally does not exist based solely on the person's investment in the voting securities of the entity. Nevertheless, the person is considered an affiliate of the entity because the person has the power to direct the management and policies of the entity. Furthermore, in order to be independent under §7.88(k)(8), a person may not be an affiliate of any subsidiary of that entity. Section §7.88(c)(14) defines the term "subsidiary" as used in §7.88 as having the meaning assigned by the Insurance Code §823.003. Section 823.003(b) provides that a person is a subsidiary of another if the person is an affiliate of and is controlled by the other person directly or indirectly through one or more intermediaries. Also, under §823.003(c), a subsidiary or holding company of a person is an affiliate of that person. The Insurance Code Chapter 823, including §§823.003, 823.005 and 823.151, and rules adopted thereunder, provide the criteria upon which to determine whether a particular audit committee member is an

"affiliate" of an entity or an "affiliate of a subsidiary" of an entity for purposes of §7.88. These statutes and rules may be consulted to properly ascertain compliance with §7.88(k).

Furthermore, §7.88(k) is modeled after and consistent with Section 14 of the NAIC Model Audit Rule, as updated in 2006. As discussed in the Introduction of the published proposal, the NAIC has adopted an implementation guide as an informational appendix to the NAIC Accountant Practices and Procedures Manual to help in the application of and compliance with the model audit requirements. Page G-10 of the current NAIC implementation guide contains some additional guidance on whether certain parties would be considered "independent." This guide indicates that a policyholder is considered "independent" unless the policyholder receives direct compensation from the insurer for other unrelated services.

§7.88(m). Management's Report of Internal Control over Financial Reporting.

Comment: One commenter contends that there is not enough guidance to implement specific internal controls over financial reporting and that more details are needed in the proposed rule.

Agency Response: The Department disagrees and declines to make the requested change. One of the Department's over-arching objectives in adopting the new rule is to address certain regulatory concerns relating to ensuring the adequacy of insurers' and HMOs' internal control structures while at the same time keeping the costs of regulatory compliance relatively low for the industry over-all. This Department

objective was a driving force in the drafting of §7.88(m). Although the Department could have proposed very prescriptive requirements in §7.88(m), including a specific framework for management's review and evaluation of internal controls, doing so would have significantly increased the costs of regulatory compliance for those insurers and HMOs required to comply with §7.88(m). Section 7.88(m) does not mandate a specific framework for management's review and evaluation of internal controls. Instead, §7.88(m) provides flexibility in meeting the management report requirements imposed in the subsection in the most cost effective means and is modeled after and consistent with Section 16 of the NAIC Model Audit Rule, as updated in 2006. Under §7.88(m)(8), management, when making its assessment and preparing its report, has discretion and flexibility about the nature of the internal control framework used. Certain guidance, however, is provided in the NAIC implementation guide to the 2006 revised Model Audit Rule. As explained on page G-14 of the implementation guide, (i) insurers and HMOs have discretion and flexibility under §7.88(m) about the frequency and scope of testing activities; and (ii) the controls included in the scope of management's report should only include those controls deemed significant or critical by management. Page G-14 also includes a non-exhaustive, illustrative list of examples of aspects and components of internal control that insurers and HMOs may want to consider when making assertions and determining relevant documentary evidence; the list of examples is not intended to serve as requirements. Page G-15 of the NAIC implementation guide further provides that management may also consider diligent inquiry of key process owners throughout the organization to provide additional assurance on the operating

effectiveness of its internal control over financial reporting. For purposes of filing the report, “diligent inquiry” means conducting a search and thorough review of relevant documents that are reasonably likely to contain significant information with regard to internal control over financial reporting and the making of reasonable inquiries of current employees and agents whose duties include responsibility for internal control over financial reporting.

Furthermore, to allow insurers and HMOs to comply with §7.88(m) in a cost effective manner, §7.88(m)(7) provides that management may base its assertions, in part, upon its review, monitoring, and testing processes performed in the normal course of its activities. Also, as explained in the Introduction of the published proposal, new §7.88(m)(7) and (8) do not expressly require that an insurer’s or HMO’s management follow a specific or prescribed protocol in documenting the basis for management’s opinions, but do expressly acknowledge and authorize an insurer’s or HMO’s management to exercise discretion and flexibility about the nature and extent of the §7.88(m)(7) documentation. This approach will enable the insurer or HMO management to form its opinions in a cost-effective manner, including an assembly of or reference to existing documentation.

Comment: Three commenters raise concerns related to the cost to comply with proposed §7.88(m). These commenters request that TDI and the Texas Health and Human Services Commission (HHSC) exempt Medicaid and Children’s Health Insurance Program (CHIP) health maintenance organizations (HMOs) from complying

with the requirement in §7.88(m) to prepare and file a management's report of internal control over financial reporting. Two of these commenters disagree with the Department's fiscal note for the published proposal, which states, in relevant part, that ". . .there will be no fiscal implications for state or local government as a result of this section. . . ." These commenters contend that while the fiscal note may be true for TDI in overseeing and administering this new requirement, it is not true for HHSC which is responsible for funding and payment of Medicaid and CHIP premiums to its contracted HMOs. These commenters argue that the incremental cost of implementing the new reporting requirement will ultimately be incurred by the State of Texas since the premiums they receive from the State of Texas must cover all of their admitted administrative costs. These two commenters also contend that the incremental cost of implementing the reporting requirement would be outside consulting firm costs and management and employee time. One of these two commenters estimates it could incur $144,000 - 184,000 in consulting costs in the initial year to comply and invest 3,300 – 4,475 hours of management and employee time in the first year of this initiative, for a total expected first year cost of $471,000 - $620,000. The second commenter states that based on estimates from outside consulting firms, it believes it would incur over $100,000 in consulting costs in the initial year to comply and invest 2,000 - 3,300 hours of management and employee time in the first year of this initiative, for a total expected first year implementation cost of $200,000 - $400,000. These commenters further state that if the exemption cannot be granted, that HHSC reconsider the $1 per member per month administrative cost reduction that was applied in State Fiscal Year

2011 rating setting methodology so that Medicaid and CHIP plans have adequate premium to cover the anticipated administrative cost to implement these new regulations. Two of these commenters also request that the two-year transition period in §7.88(n)(2) for filing the management report on internal control be clarified to apply to insurers and HMOs that exceed the $500 million premium threshold for the first time in 2010. One of these commenters requests clarification as to the exact date that the first management report on internal control would be required to be filed with the Department, assuming that the Department agrees to make the requested clarification to §7.88(n)(2).

Agency Response: The Department disagrees that its fiscal note for the proposal incorrectly estimates the fiscal implications for the state or local governments, and declines to adopt the commenters' suggested change to add an exemption in §7.88(m) for Medicaid and CHIP HMOs for several reasons. In order to explain the Department's reasons for declining to add the suggested exemption to §7.88(m) for Medicaid and CHIP HMOs, it is necessary to review the Department's cost note. First, the Department's published cost note clearly and unambiguously points out that any elective costs, such as outside consulting costs, are not required to implement the §7.88(m) reporting requirements. The cost note states that while the Department anticipates that some insurers or HMOs may elect at their option to utilize external accounting firms to assist in preparing the management reports required by proposed new §7.88(m)(1) or (2) and (3), (4), (5), (6), and (8), these rule provisions, unlike SOX Section 404, do not require that an insurer's or HMO's external accountant assist in

either preparing the management report or in providing an attestation report on the effectiveness of the internal controls over financial reporting. Section 7.88(m) specifically requires management to prepare the report. Because the §7.88(m) reporting requirements do not require an insurer or HMO to use an external accounting firm in preparing the management report, any insurer or HMO that uses an external accounting firm would do so at its option, and any such costs incurred by the insurer or HMO would be elective costs. Such costs would not be considered a required cost to comply with §7.88(m). Therefore, to the extent HHSC ever increased premium payments to Medicare and CHIP HMOs based upon any incurred elective consulting costs to prepare the §7.88(m) management report, the resulting costs to state government would not be incurred as a result of enforcing or administering adopted §7.88 but would rather result from the election by the Medicare and CHIP HMOs to employ an external accounting firm. Second, the Department's cost note states that the probable costs of compliance with proposed §7.88(m) typically can be implemented with existing staff. The cost note points out that because management is directly responsible for preparing the report and making the attestation in the report, the Department anticipates that most insurers or HMOs typically will utilize their own staff to prepare the §7.88(m) management report on internal controls. The cost note further explains that although the project may require a substantial amount of time for completion, the Department anticipates that the insurer's or HMO's staff will typically be able to concurrently engage in their routine functions and prepare the required report. Therefore, an insurer or HMO, including a Medicaid or CHIP HMO, is not expected to

incur additional expenses to hire additional staff to comply with the proposed §7.88(m) reporting requirements. Third, the Department's cost note explains that prudently operated insurers or HMOs often will incur comparatively less costs to comply with proposed new §7.88(m)(1) or (2), and (3), (4), (5), (6), and (8) compared to less prudently operated insurers or HMOs. Prudently operated entities typically will already have an adequate system of internal controls in place and will therefore not need to incur substantial costs for compliance with the proposed new §7.88(m)(1) or (2) and (3) – (8) internal control requirements. Therefore, any prudently operated insurer or HMO, including Medicaid and CHIP HMOs, should not incur substantial costs to prepare and file the management report of internal control over financial reporting. Fourth, the Department's cost note states that proposed new §7.88(m)(8) expressly acknowledges and authorizes an insurer's or HMO's management to utilize its discretion about the nature of the internal control framework used and the nature and extent of the §7.88(m)(7) documentation to enable the insurer or HMO management to form its opinions in a cost-effective manner. Section 7.88(m)(7) and (8) together allow an insurer or HMO to exercise discretion and flexibility in determining its means of compliance, including the most cost-effective means for that particular insurer or HMO. Fifth, insurers and HMOs, including CHIP or Medicaid HMOs, that are subject to the §7.88(m) reporting requirements could make written application to the Commissioner for a hardship exemption to the §7.88(m) reporting requirement in accordance with the provisions of the Insurance Code §401.008. Section 401.008(b) provides that subject to §401.008(c), the Commissioner may grant an exemption if the Commissioner finds,

after reviewing the application, that compliance with this subchapter would constitute a severe financial or organizational hardship for the insurer or health maintenance organization. Whether a particular insurer or HMO is granted an exemption under §401.008(b) is a case-by-case, fact specific determination. Because §401.008(b) already provides a means for an insurer or HMO to apply to the Commissioner for a hardship exemption to the §7.88(m) reporting requirements, it is not necessary to exempt all Medicare or CHIP HMOs from the §7.88(m) reporting requirements.

With regard to the commenters' estimated costs for compliance with the proposed §7.88(m) requirement to prepare and file a management's report of internal control over financial reporting, the Department disagrees that an insurer or HMO is required to incur such costs to comply with the §7.88(m) reporting requirement. As previously explained, the §7.88(m) reporting requirements do not require an insurer or HMO to use an external accounting firm in preparing the management report; any insurer or HMO that uses an external accounting firm would do so at its option, and any such costs incurred by the insurer or HMO would be elective costs. In addition, as previously explained in detail, the Department anticipates that the insurer's or HMO's staff will typically be able to concurrently engage in their routine functions and prepare the required report at no additional expense to the insurer or HMO.

Therefore, because an insurer or HMO, including a CHIP or Medicaid HMO, can use existing staff and resources to comply with the proposed §7.88(m) reporting requirements in the most cost-effective, prudent manner for that particular insurer and HMO, and because the rules provide for the application for a hardship exemption to the

7.88(m) requirements, the Department declines to adopt the commenters' suggested change to add an exemption in §7.88(m) for Medicaid and CHIP HMOs.

In order to address the questions and concerns raised by the commenters relating to the cost to comply with proposed §7.88(m) and the applicability of the two-year transition period in proposed §7.88(n)(2) for filing the management report on internal control, the Department has changed the transition period in proposed §7.88(n) to provide that insurers and HMOs that reach the $500 million premium transition threshold for the first time for the reporting period ending December 31, 2010, will have a two-year transition period to comply with §7.88(m). Section 7.88(n)(2) as adopted provides that "An insurer or HMO required to file an audited financial report under the 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 periods must comply with the reporting requirements in subsection (m) 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." As a result, if an insurer or HMO required to file an audited financial report reaches the requisite $500 million premium threshold for the first time for the reporting period ending December 31, 2010, and the insurer or HMO continues to meet the premium threshold for the reporting periods ending December 31, 2011, and December 31, 2012, the insurer or HMO will

be required to file a report effective December 31, 2012, with the §7.88(j) communication of internal control matters noted in the audit not later than the 60th day after the date the audited financial report is filed. Assuming that the insurer or HMO is required to file the audited financial report no later than June 30, 2013, pursuant to §7.88(d)(2), the report would be due no later than August 29, 2013.

Section 7.88(n)(2) as proposed is redesignated as §7.88(n)(3) in this adoption as a result of this change in the transition period with one nonsubstantive change to the proposed text to add the word “required” between the word “amount” and the phrase “to file the report.” Section 7.88(n)(3) as adopted specifies the transition period for an insurer or HMO or group of insurers or HMOs with less than the requisite premium threshold amount for the reporting period ending December 31, 2010, but that exceeds the required premium threshold amount in a subsequent reporting period.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For: American Council of Life Insurers.

Neither for nor against: Texas Association of Life and Health Insurers and Mitchell, Williams, Long, Burner.

Neither for nor against, with changes: Cook Children’s Health Plan, Texas Children’s Health Plan, Inc., and Parkland Community Health Plan, Inc.

6. STATUTORY AUTHORITY. The new section is adopted under the Insurance Code Chapters 32, 401, 404, 421, 441, 541, 801, 802, 822, 823, 841, 843, and 884, and

§36.001. Section 32.041 requires the Department to furnish to the companies required to report to the Department the statement blanks and other reporting forms necessary for companies to comply with the filing requirements.

Chapter 401 regulates solvency. Section 401.001 defines the terms “accountant,” “affiliate,” “health maintenance organization,” “insurer,” and “subsidiary” that are used in the Insurance Chapter 401, Subchapter A. Section 401.004(a) provides that unless exempt under the Insurance Code §§401.006, 401.007, or 401.008 and except as otherwise provided by §401.005 and §401.016, an insurer or health maintenance organization must have an annual audit performed by an accountant and must file an audited financial report for the preceding calendar year with the Commissioner on or before June 30. Section 401.004(b) authorizes the Commissioner to require an insurer or health maintenance organization to file an audited financial report on a date that precedes June 30 and requires the Commissioner to notify the insurer or health maintenance organization of the filing date not later than the 90th day before that filing date. Section 401.004(c) authorizes an insurer or health maintenance organization to request an extension of the filing date for the audited financial report, under certain specified conditions, including submitting the request in writing before the 10th day preceding the filing date. Section 401.005 provides that an insurer or health maintenance organization domiciled in Canada or the United Kingdom may file the insurer's or health maintenance organization's annual statement of total business on the form filed by the insurer or health maintenance organization with the appropriate regulatory authority in the country of domicile; this is in lieu of filing the audited financial

report required by the Insurance Code §401.004 and only if certain specified conditions are met. Section 401.006 provides exemptions from the requirement to file an audited financial report for insurers or health maintenance organizations that have less than $1 million in direct premiums written in this state during a calendar year and that meet certain specified conditions. Section 401.007 provides exemptions from the requirement to file an audited financial report under the Insurance Code Chapter 401, Subchapter A, for an alien or foreign insurer or health maintenance organization that files an audited financial report in another state in accordance with that state's requirements for audited financial reports if the Commissioner finds that the other state's requirements are substantially similar to the requirements prescribed by Chapter 401, Subchapter A. Section 401.008 allows an insurer or health maintenance organization that is not eligible for an exemption under the Insurance Code §401.006 or §401.007 to apply to the Commissioner for a hardship exemption and authorizes the Commissioner to grant the application under certain specified conditions. Section 401.009(a) - (c) specifies the contents of an audited financial report required under the Insurance Code §401.004. The contents must include (i) a description of the financial condition of the insurer or health maintenance organization as of the end of the most recent calendar year and the results of the insurer's or health maintenance organization's operations, changes in financial position, and changes in capital and surplus for that year; (ii) the report of an accountant; (iii) a balance sheet that reports admitted assets, liabilities, capital, and surplus; (iv) a statement of gain or loss from operations; (v) a statement of cash flows; (vi) a statement of changes in capital and surplus; (vii) any notes to

financial statements; (viii) supplementary data and information, including any additional data or information required by the Commissioner; and (ix) information required by the Department to conduct the insurer's or health maintenance organization's examination under the Insurance Code Chapter 401, Subchapter B. Section 401.009(b) specifies the contents of the notes to financial statements required by §401.009(a)(3)(F), including (i) a reconciliation of any differences between the filed audited statutory financial statements and the annual statements with a written description of the nature of those differences; (ii) any notes required by the appropriate National Association of Insurance Commissioners annual statement instructions or by generally accepted accounting principles; and (iii) a summary of the ownership of the insurer or health maintenance organization and that entity's relationship to any affiliated company. Section 401.009(d) requires the Commissioner to adopt rules governing the information required to be included in the audited financial report under the Insurance Code §401.009(a)(3)(H). Section 401.010(a) requires an accountant to audit the financial reports provided by an insurer or health maintenance organization for purposes of an audit under the Insurance Code Chapter 401, Subchapter A. Section 401.010(a) further requires the accountant who audits the reports to conduct the audit in accordance with generally accepted auditing standards or with standards adopted by the Public Company Accounting Oversight Board, as applicable. The accountant is required to consider the standards specified in the Financial Condition Examiner's Handbook adopted by the National Association of Insurance Commissioners or other analogous nationally recognized standards adopted by Commissioner rule. Section 401.010(b)

requires the financial statements included in the audited financial report to be prepared in a form and using language and groupings substantially the same as those of the relevant sections of the insurer's or health maintenance organization's annual statement filed with the Commissioner. Section 401.010(b) further requires that beginning in the second year in which an insurer or health maintenance organization is required to file an audited financial report, the financial statements must also be comparative, presenting the amounts as of December 31 of the reported year and the amounts as of December 31 of the preceding year. Section 401.011(a) provides that except as provided by §401.011(c) and (d), the Commissioner shall accept an audited financial report from an independent certified public accountant or accounting firm that (1) is a member in good standing of the American Institute of Certified Public Accountants and is in good standing with all states in which the accountant or firm is licensed to practice, as applicable; and (2) 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. Section 401.011(d) provides that the Commissioner may not accept an audited financial report prepared wholly or partly by an individual or firm that the Commissioner finds (1) has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act (18 U.S.C. Section 1961 et seq.), or a state or federal criminal offense involving dishonest conduct; (2) has violated the insurance laws of this state with respect to a report filed under the Insurance Code Chapter 401, Subchapter A; (3) has demonstrated a pattern or practice of failing to detect or disclose material

information in reports filed under this subchapter; or (4) has directly or indirectly entered into an agreement of indemnity or release of liability regarding an audit of an insurer. Section 401.012 provides that the Commissioner may hold a hearing to determine if an accountant is qualified and independent. Section 401.012 further provides that if, after considering the evidence presented, the Commissioner determines that an accountant is not qualified and independent for purposes of expressing an opinion on the financial statements in an audited financial report filed under this subchapter, the Commissioner shall issue an order directing the insurer or health maintenance organization to replace the accountant with a qualified and independent accountant. Section 401.013 mandates that the audited financial report required under the Insurance Code §401.004 must be accompanied by a letter provided by the accountant who performed the audit stating (1) the accountant's general background and experience; (2) the experience of each individual assigned to prepare the audit in auditing insurers or health maintenance organizations and whether the individual is an independent certified public accountant; and (3) that the accountant (A) is properly licensed by an appropriate state licensing authority, is a member in good standing of the American Institute of Certified Public Accountants, and is otherwise qualified under the Insurance Code §401.011; (B) is independent from the insurer or health maintenance organization and conforms to the standards of the profession contained in the American Institute of Certified Public Accountants Code of Professional Conduct, the statements of that institute, and the rules of professional conduct adopted by the Texas State Board of Public Accountancy, or a similar code; (C) understands that (i) the audited financial

report and the accountant's opinion on the report will be filed in compliance with the Insurance Code Chapter 401, Subchapter A; and (ii) the Commissioner will rely on the report and opinion in monitoring and regulating the insurer's or health maintenance organization's financial position; and (D) consents to the requirements of the Insurance Code §401.020 and agrees to make the accountant's work papers available for review by the Department or the Department's designee. Section 401.014(a) requires an insurer or health maintenance organization to register in writing with the Commissioner the name and address of the accountant retained to prepare the audited financial report for the insurer or health maintenance organization. Section 401.014(d) provides that the Commissioner may not accept the registration of a person who does not qualify under the Insurance Code §401.011 or does not comply with the other requirements of the Insurance Code Chapter 401, Subchapter A. Section 401.016 provides that an insurer or health maintenance organization described by §401.001(3) or (4) that is required to file an audited financial report may apply in writing to the Commissioner for approval to file audited combined or consolidated financial statements instead of separate audited financial reports if the insurer or health maintenance organization meets certain statutorily specified conditions. Section 401.017(a) requires an insurer or health maintenance organization required to file an audited financial report under the Insurance Code Chapter 401, Subchapter A, to require the insurer's or health maintenance organization's accountant to immediately notify the board of directors of the insurer or health maintenance organization or the insurer's or health maintenance organization's audit committee in writing of any determination by that accountant that

the insurer or health maintenance organization has materially misstated the insurer's or health maintenance organization's financial condition as reported to the Commissioner as of the balance sheet date being audited, or that the insurer or health maintenance organization does not meet the minimum capital and surplus requirements prescribed by the Insurance Code for the insurer or health maintenance organization as of that date. Section 401.018 provides that if, after the date of an audited financial report filed under the Insurance Code Chapter 401, Subchapter A, the accountant becomes aware of facts that might have affected the report, the accountant must take action as prescribed in Volume 1, AU Section 561, Professional Standards of the American Institute of Certified Public Accountants. Section 401.019 provides that in addition to the audited financial report required by the Insurance Code Chapter 401, Subchapter A, each insurer or health maintenance organization shall provide to the Commissioner a written report of significant deficiencies required and prepared by an accountant in accordance with the Professional Standards of the American Institute of Certified Public Accountants; and shall annually file with the Commissioner the report required by this section not later than the 60th day after the date the audited financial report is filed. Section 401.019 further provides that the insurer or health maintenance organization shall provide a description of remedial actions taken or proposed to be taken to correct significant deficiencies, if the actions are not described in the accountant's report. Section 401.019 further requires that the report must follow generally the form for communication of internal control structure matters noted in an audit described in Statement on Auditing Standard (SAS) No. 60, AU Section 325, Professional Standards

of the American Institute of Certified Public Accountants. New §7.88(j) is consistent with the new SAS No. 112 which supersedes SAS No. 60. Section 401.020(b) requires an insurer or health maintenance organization required to file an audited financial report under the Insurance Code Chapter 401, Subchapter A, to require the insurer's or health maintenance organization's accountant to make available for review by the Department's examiners the work papers and any record of communications between the accountant and the insurer or health maintenance organization relating to the accountant's audit that were prepared in conducting the audit. Section 401.020(b) further mandates the time periods for the retention of the accountant’s work papers and records of communication. Section 401.020(c) authorizes the Department to copy and retain the copies of pertinent work papers when the Department's examiners conduct a review under §401.020(b). Section 401.020(c) also provides that the review is considered an investigation, and work papers obtained during that investigation may be made confidential by the Commissioner, unless the work papers are admitted as evidence in a hearing before a governmental agency or in a court. Section 401.021 provides that if an insurer or health maintenance organization fails to comply with the Insurance Code Chapter 401, Subchapter A, the Commissioner shall order that the insurer's or health maintenance organization's annual audit be performed by a qualified independent certified public accountant and authorizes the Commissioner to assess against the insurer or health maintenance organization the cost of auditing the insurer's or health maintenance organization's financial statement. Sections 401.051 and 401.056 mandate that the Department examine the financial condition of each insurer or

health maintenance organization organized under the laws of Texas or authorized to transact the business of insurance in Texas. Section 401.056 requires the Commissioner to adopt rules relating to procedures governing the filing and adoption of an examination report and hearings to be held under the Insurance Code, Chapter 401, Subchapter B (Examination of Insurers or HMOs).

Chapters 404 addresses the duties of the Department when an insurer's condition might indicate it is in a hazardous condition or when an insurer's solvency is impaired. Chapter 404 authorizes the Commissioner to set standards for evaluating the financial condition of an insurer. Section 404.003(a) authorizes the Commissioner to order an insurer, after notice and hearing, to take action reasonably necessary to remedy the condition if the financial condition of an insurer, when reviewed as provided by §404.003(b), indicates a condition that might make the insurer's continued operation hazardous to the insurer's policyholders or creditors or to the public. Section 404.005(a) authorizes the Commissioner to establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and standards for evaluating the financial condition of an insurer. Section 404.005(b) requires the standards established by the Commissioner under §404.005(a) to be consistent with the purposes of §404.003. Section 404.053(a) provides that if the Commissioner determines that any of the circumstances described in §404.053(a)(1)(A) or (B) or (a)(2)(A) or (B) exist, the Commissioner shall order an insurer to remedy an impairment of the insurer's surplus, aggregate surplus, or aggregate of guaranty fund and surplus, as applicable, by

bringing the surplus to an acceptable level specified by the Commissioner. Section 404.053(b) requires that, after issuing an order described in §404.053(a), the Commissioner immediately institute any proceeding necessary to determine what further actions the Commissioner will take in relation to the matter.

Chapters 421 addresses the reserves required for an insurer. Section 421.001(c) requires the Commissioner to adopt each current formula recommended by the National Association of Insurance Commissioners for establishing reserves applicable to each line of insurance.

Chapter 441 addresses the prevention of insurer delinquencies. Section 441.001(e) sets forth the purpose of Chapter 441: (i) provide for the rehabilitation and conservation of insurers by authorizing and requiring supervision and conservatorship by the commissioner; (ii) authorize action to determine whether an attempt should be made to rehabilitate and conserve an insurer; (iii) avoid, if possible and feasible, the necessity of placing an insurer under temporary or permanent receivership; (iv) provide for the protection of an insurer's assets pending determination of whether the insurer may be successfully rehabilitated; and (v) alleviate concerns regarding insurance and insurers. Section 441.005 authorizes the Commissioner to adopt reasonable rules as necessary to implement and supplement Chapter 441 of the Insurance Code (Supervision and Conservatorship). Section 441.051 specifies “the circumstances in which an insurer is considered insolvent, delinquent, or threatened with delinquency” and includes certain statutorily specified conditions, including if an insurer’s required surplus, capital, or capital stock is impaired to an extent prohibited by law. Section

441.052 specifies the circumstances in which an insurer is considered to have exceeded the insurer's powers, including circumstances in which the insurer is in a condition that makes the insurer's continuation in business hazardous to the public or to the insurer's policyholders or certificate holders. Section 441.053 provides that if at any time the Commissioner determines that an insurer is insolvent, has exceeded the insurer's powers, or has otherwise failed to comply with the law, the Commissioner shall: (i) notify the insurer of that determination; (ii) provide to the insurer a written list of the Commissioner's requirements to abate the conditions on which that determination was based; and (iii) if the Commissioner determines that the insurer requires supervision, notify the insurer that the insurer is under Commissioner's supervision and that the Commissioner is invoking Chapter 441. Section 441.102 requires an insurer under supervision to comply with the Commissioner's requirements under §441.053 not later than the 180th day after the date of the Commissioner's notice of supervision.

Chapter 541 of the Insurance Code addresses unfair methods of competition and unfair or deceptive acts or practices. Section 541.051(3) provides that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to make a misleading representation or misrepresentation regarding the financial condition of an insurer, or the legal reserve system on which a life insurer operates. Section 541.055(a) provides that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to, with intent to deceive, file with a supervisory or other public official a false statement of financial condition of an insurer; or make, publish, disseminate, circulate, deliver to any person, or place

before the public or directly or indirectly cause to be made, published, disseminated, circulated, delivered to any person, or placed before the public a false statement of financial condition of an insurer. Section 541.055(b) provides that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to make a false entry in an insurer's book, report, or statement or willfully omit to make a true entry of a material fact relating to the insurer's business in the insurer's book, report, or statement with intent to deceive an agent or examiner lawfully appointed to examine the insurer's condition or affairs, or a public official to whom the insurer is required by law to report or who has authority by law to examine the insurer's condition or affairs. Section 541.401 authorizes the Commissioner to adopt reasonable rules necessary to accomplish the purposes of trade practices regulation in Chapter 541.

Chapter 801 of the Insurance Code addresses regulations related to the certificate of authority of insurers and related entities. Section 801.101 authorizes the Commissioner to inquire into the competence, fitness, or reputation of (i) an officer or director of an insurer; or (ii) a person having control of an insurer. Section 801.102 provides that if after conducting an inquiry under §801.101 the Department determines that, based on substantial evidence, the person who is the subject of the inquiry is not worthy of public confidence, the Department shall, after written notice and hearing (i) deny the application for a certificate of authority; or (ii) revoke the insurer’s certificate of authority.

Chapter 802 of the Insurance Code regulates the annual statements of insurers and related entities. Section 802.001 authorizes the Commissioner, as necessary, to

obtain an accurate indication of the company's condition and method of transacting business, to change the form of any annual statement required to be filed by any kind of insurance company, and to require certain insurers to make filings with the National Association of Insurance Commissioners. Section 802.002 provides that an insurance company's annual statement must include a statement of a qualified actuary titled "Statement of Actuarial Opinion" that (i) is located on or attached on the first page of the annual statement; and (2) provides the opinion of the actuary relating to policy reserves and other actuarial items for life insurance, accident and health insurance, and annuities, or loss and loss adjustment expense reserves for property and casualty risks as described in the annual statement instructions of the National Association of Insurance Commissioners as appropriate for the types of risks insured. Section 802.052(a) requires each domestic, foreign, or alien insurance company authorized to engage in the business of insurance in this state to file a copy of the company's annual statement with the National Association of Insurance Commissioners at the time the company files the statement with the Commissioner. Section 802.052(b) requires the statement required by §802.052(a) to (1) meet the requirements adopted by the Commissioner, including: (A) a change in substance or form; (B) an additional filing; and (C) any requirement that the statement be in a computer compatible format; and (2) include the signed jurat page and the actuarial opinion, as required by the jurisdiction in which the insurance company is domiciled. Section 802.053 authorizes the Commissioner to exempt any class of insurance companies from the requirements of Chapter 802, Subchapter B, if the Commissioner believes the information required

under Subchapter B will not be useful for regulatory purposes. Section 802.054 provides that the Commissioner may consider a foreign insurance company to be in compliance with the requirements of §802.052 if the company is domiciled in a state with a law substantially similar to that section.

Sections 822.210 (Commissioner May Require Larger Capital and Surplus Amounts for Insurance Companies Other than Life, Health, or Accident Insurance Companies), 841.205 (Commissioner May Require Larger Capital and Surplus Amounts for Life, Health, or Accident Insurance Companies), 843.404 (Additional Net Worth Requirements for Health Maintenance Organizations), and 884.206 (Commissioner May Require Larger Capital and Surplus Amounts for Stipulated Premium Insurance Companies) authorize the Commissioner to adopt rules to require an insurer to maintain capital and surplus levels in excess of statutory minimum levels or an HMO to maintain a specified net worth to assure financial solvency of insurers or HMOs for the protection of policyholders and insurers or enrollees and HMOs, as applicable. Section 822.211 provides that if an insurance company does not comply with the capital and surplus requirements of Chapter 822, the Commissioner may (i) enter an order prohibiting the company from writing new business and placing the company under state supervision or conservatorship; (ii) declare the company to be in a hazardous condition as provided by Subchapter A, Chapter 404; (iii) declare the company to be impaired as provided by Subchapter B, Chapter 404; or (iv) apply to the company any other applicable sanction as provided by the Insurance Code. Section 841.207 provides that if an insurance company does not comply with the capital and surplus requirements of Chapter 841, the

Commissioner may (i) enter an order prohibiting the company from writing new business and placing the company under state supervision or conservatorship; (ii) declare the company to be in a hazardous condition as provided by Subchapter A, Chapter 404; (iii) declare the company to be impaired as provided by Subchapter B, Chapter 404; or (iv) apply to the company any other applicable sanction as provided by the Insurance Code. Section 841.206 provides that if the Commissioner determines that an insurance company's capital or surplus is impaired in violation of §841.206, the Commissioner shall order the insurer to immediately reduce the level of impairment to an acceptable level of impairment as specified by the Commissioner or prohibit the company from engaging in the business of insurance in this state, and begin proceedings as necessary to determine any further actions with respect to the impairment.

Section 823.157 (Approval of Acquisition of Control of Holding Company Systems) requires the Commissioner to consider, in determining whether to approve or deny an acquisition for change of control for which a Subchapter E statement is filed under §823.154, whether (i) immediately on the acquisition or change of control, the domestic insurer would not be able to satisfy the requirements for the issuance of a new certificate of authority to write the line or lines of insurance for which the insurer holds a certificate of authority; (ii) the effect of the acquisition or change of control would be to substantially lessen competition in any line or sub-classification lines of insurance in this state or tend to create a monopoly in a line or sub-classification lines of insurance in this state; (iii) the financial condition of the acquiring person may jeopardize the financial

stability of the domestic insurer or prejudice the interest of its policyholders; (iv) the acquiring person has any plan or proposal to liquidate the domestic insurer or cause the insurer to declare dividends or make other distributions, sell any of its assets, consolidate or merge with any person, make a material change in its business or corporate structure or management, or enter into any material agreement, arrangement, or transaction of any kind with any person, and that the plan or proposal is unfair, prejudicial, hazardous, or unreasonable to the domestic insurer's policyholders and not in the public interest; (v) due to a lack of competence, trustworthiness, experience and integrity of the persons who would control the operations of the domestic insurer, the acquisition or change of control would not be in the interest of the insurer's policyholders and of the public; or (vi) the acquisition or change of control would violate the law of this state or another state or the United States.

Chapter 843 of the Insurance Code regulates health maintenance organizations. Section 843.151 authorizes the Commissioner to adopt reasonable rules as necessary to carry out the provisions of Chapter 843, §1367.053 (related to Coverage Required for Childhood Immunization), Subchapter A of Chapter 1452 (Physicians and Provider Credentials); Subchapter B of Chapter 1507 (Health Benefit Plans for Children), Chapters 222 (Life, Health, and Accident Insurance Premium Tax), 251 (General Provisions), and 258 (Health Maintenance Organizations) as applicable to a health maintenance organization, and Chapters 1271 (Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges) and 1272 (Delegation of Certain Functions by Health Maintenance Organizations). Section 843.155 requires

HMOs to file annual reports with the Commissioner, which include a financial statement of the HMO, verified by at least two principal officers and certified by an independent public accountant. Section 843.157 provides that the rehabilitation, liquidation, supervision, or conservation of a health maintenance organization shall be treated as a rehabilitation, liquidation, supervision, or conservation of an insurer and be conducted under the supervision of the Commissioner under Chapter 441 or 443, as appropriate. Section 843.406 authorizes the Commissioner to establish, in a manner consistent with the purposes of §843.406, uniform standards and criteria for early warning that the continued operation of a health maintenance organization could be hazardous to the health maintenance organization's enrollees or creditors or the public and standards for evaluating the financial condition of a health maintenance organization.

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

7. TEXT.

§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 the 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 the 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, shall be 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.

(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 the Insurance Code §401.011.

(2) Affiliate--Has the meaning assigned by the 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 the Insurance Code Chapter 401, Subchapter A.

(5) Group of insurers or HMOs--Those authorized insurers or HMOs included in the reporting requirements of the 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;

(O) a stipulated premium company; and

(P) a nonprofit legal services corporation.

(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 the 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 the 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 the Insurance Code §401.004(c). An extension granted under the 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 (m) of this section.

(5) An insurer or HMO required to file an annual audited financial report under the Insurance Code Chapter 401, Subchapter A, and this section shall 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 the Insurance Code §401.007(a) shall 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 the 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 (m)(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 the 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 (m) 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 the Insurance Code §401.011(b) and (d), and paragraphs (1), (3), (4), (5), and (10) of this subsection, the commissioner shall 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 shall 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 shall file the approval in an electronic format acceptable to the National Association of Insurance Commissioners.

(3) In providing services, the accountant shall 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 shall 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. Section 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 the 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 the 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 shall 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 shall 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 the 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 the 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 the 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 shall 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 the Insurance Code Chapter 401, Subchapter A, applies shall 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 (9) 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 the Insurance Code Chapters 822, 841, 843, or 884 or rules adopted

thereunder, including §7.402 of this chapter (relating 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 the Insurance Code Chapter 404, 441, or 843 or rules adopted thereunder, including Chapter 8 of this title (relating to Early Warning System for Insurers in Hazardous Condition) and §11.810 (relating to Hazardous Conditions for HMOs) of this title; 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), and (5) – (12) 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 shall 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 the Insurance Code Chapter 401, Subchapter A, and this section. Each accountant shall report directly to the audit committee.

(7) 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 (10) of this subsection and described under subsection (c)(3) of this section.

(8) 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.

(9) 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.

(10) 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.

(11) The audit committee shall require the accountant who performs an audit required by the 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.

(12) If an insurer or HMO is a member of an insurance holding company system, the report required by paragraph (11) 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) 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 the 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 the 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 the 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.

(m) Report of Internal Control over Financial Reporting.

(1) Each insurer or HMO required to file an audited financial report under the 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 shall 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 the 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 §11.810 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 the 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 the 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 shall 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 the Insurance Code §401.058 and information described by the Insurance Code §401.201.

(n) 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 the 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 (m) 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 (m)(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.

(o) 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.

Issued at Austin, Texas, on August 10, 2010.

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

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that new §7.88 specified herein, concerning independent annual audits of insurer and health maintenance organization (HMO) financial statements, is adopted.

AND IT IS SO ORDERED.

MIKE GEESLIN
COMMISSIONER OF INSURANCE

ATTEST:

Gene C. Jarmon
General Counsel and Chief Clerk
COMMISSIONER'S ORDER NO. 10-0726
AUG 11 2010