

**SUBCHAPTER F. PROFESSIONAL EMPLOYER ORGANIZATIONS  
SPONSORING SELF-FUNDED EMPLOYEE HEALTH BENEFIT PLANS  
§§13.510 - 13.582**

**DIVISION 1. PURPOSE AND DEFINITIONS**

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

**§13.511. Applicability; Approval Required.**

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

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

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

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

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

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

(1) licensed and in good standing with the Texas Department of Licensing and Regulation (TDLR); and

(2) has a certificate of approval from the Texas Department of Insurance (TDI) issued under this subchapter.

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

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

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

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

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

(1) Affiliate--A person is an affiliate of another if the person directly or indirectly through one or more intermediaries controls or is controlled by, or is under common control with another person. A person is a subsidiary of another if the person is an affiliate of and is directly

controlled by the other person or indirectly through one or more intermediaries. A subsidiary or holding company of a person is an affiliate of that person.

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

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

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

(5) Coemployment relationship--A contractual relationship between a client and a PEO that involves the sharing of employment responsibilities with or allocation of employment responsibilities to covered employees in compliance with the professional employer services agreement and Labor Code Chapter 91, concerning Professional Labor Organizations.

(6) Commissioner--The commissioner of insurance.

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

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

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

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

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

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

(11) Health status-related factor--Health status; medical condition, including both physical and mental illnesses; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

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

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

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

(13) Participant--A covered employee or dependent enrolled in a plan.

(14) Person--An individual, corporation, partnership, association, joint stock company, trust, or unincorporated organization, or a similar entity or a combination of the listed

entities acting in concert. The term does not include a securities broker while performing no more than a function that is usual and customary for a securities broker.

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

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

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

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

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

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

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

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

(21) Trust--A trust established under Texas Property Code Title 9, Subtitle B, and ERISA §403, 29 U.S.C. Section 1103 (Establishment of Trust).

(22) Ultimate controlling person--That person which is not controlled by another person.

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

**§13.520. Applicability of Insurance Code Provisions to an Approved PEO, Plan, or Trust.**

(a) Necessary Insurance Code provisions. Under Labor Code §91.0411, this division lists Insurance Code and Administrative Code provisions that are necessary to augment and implement the regulation of a PEO-sponsored employee health benefit plan that is not fully insured.

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

(c) PEO plan as large employer health benefit plan. For purposes of this subchapter, and for purposes of regulation by TDI, an approved PEO's employee health benefit plan is a large employer health benefit plan, as defined in Insurance Code Chapter 1501.

**§13.521. Delegation of Functions to a Contracting Regulated Entity.**

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

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

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

(d) Notice of termination of contract with regulated entity. An approved PEO or the plan trustees must give the commissioner a written notice of intent to terminate a contract with a regulated entity thirty days before the effective date of that termination, except that:

(1) if the contract is terminated for cause as permitted by its terms, the approved PEO or the plan trustees must give the commissioner a written notice of the contract's termination within five days of the effective date of that termination; and

(2) a written notice given under this subsection must include a statement explaining whether the functions for which the terminating contracting regulated entity is responsible will be performed by the approved PEO, or by another contracting regulated entity.

(e) Replacement contracting regulated entity. If an approved PEO or the plan trustees intend to enter into a contract with a regulated entity to perform the functions for which the terminating contracting regulated entity was responsible, the approved PEO or the plan trustees must provide the commissioner notice that complies with subsection (c) of this section.

**§13.522. Applicable Insurance Code Provisions.**

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

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

- (2) Insurance Code Chapter 36, Subchapter D, concerning Judicial Review;
- (3) Insurance Code §38.001, concerning Inquiries;
- (4) Insurance Code Chapter 38, Subchapter C, concerning Data Collection and Reporting Relating to HIV and AIDS;
- (5) Insurance Code Chapter 38, Subchapter F, concerning Data Collecting and Reporting Relating to Mandated Health Benefits and Mandated Offers of Coverage;
- (6) Insurance Code Chapter 38, Subchapter H, concerning Health Care Reimbursement Rate Information;
- (7) Insurance Code Chapter 40, concerning Duties of State Office of Administrative Hearings and Commissioner in Certain Proceedings; Rate Setting Proceedings;
- (8) Insurance Code Chapters 82, concerning Sanctions;
- (9) Insurance Code Chapter 83, concerning Emergency Cease and Desist Orders;
- (10) Insurance Code Chapter 84, concerning Administrative Penalties;
- (11) Insurance Code Chapter 101, concerning Unauthorized Insurance;
- (12) Insurance Code Chapter 461, concerning General Provisions;
- (13) Insurance Code §521.005, concerning Notice to Accompany Policy;
- (14) Insurance Code Chapter 541, Subchapter A, concerning General Provisions;
- (15) Insurance Code Chapter 541, Subchapter B, concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Defined;
- (16) Insurance Code Chapter 541, Subchapter B-1, concerning Advertising Requirements;

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

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

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

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

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

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

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

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

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

(26) Insurance Code §550.002, concerning Increase in Certain Premium

Payments;

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

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

(29) Insurance Code Chapter 601, concerning Privacy;

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

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

- (32) Insurance Code Chapter 705, concerning Misrepresentations by Policyholders;
- (33) Insurance Code Chapter 801, concerning Certificate of Authority;
- (34) Insurance Code Chapter 803, concerning Location of Books, Records, Accounts, and Offices Outside of this State;
- (35) Insurance Code Chapter 804, concerning Service of Process;
- (36) Insurance Code Chapter 823, Subchapter B, concerning Registration;
- (37) Insurance Code Chapter 823, Subchapter C, concerning Transactions of Registered Insurer;
- (38) Insurance Code Chapter 848, concerning Health Care Collaboratives;
- (39) Insurance Code §1201.013, concerning Programs Promoting Disease Prevention, Wellness, and Health;
- (40) Insurance Code §1201.059, concerning Termination of Coverage Based on Age of Child in Individual, Blanket, or Group Policy;
- (41) Insurance Code §1201.062, concerning Coverage for Certain Children in Individual or Group Policy or in Plan or Program;
- (42) Insurance Code §1201.063, concerning Prohibition of Certain Criteria Relating to a Child's Coverage in Individual or Group Policy;
- (43) Insurance Code §1201.064, concerning Coverage for Child of Spouse in Individual or Group Policy;
- (44) Insurance Code Chapter 1203, concerning Coordination of Benefits Provisions;

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

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

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

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

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

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

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

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

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

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

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

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

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

(58) Insurance Code Chapter 1216, concerning Out-of-Country Coverage

Prohibited;

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

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

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

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

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

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

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

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

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

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

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

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

(71) Insurance Code Chapter 1357, concerning Mastectomy;

(72) Insurance Code Chapter 1358, concerning Diabetes;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(98) Insurance Code Chapter 1501, Subchapter D, concerning Guaranteed Issue of Small Employer Health Benefit Plans; Continuation of Coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Applicable Administrative Code provisions. The following provisions of Title 28 of the Texas Administrative Code are applicable to an approved PEO, or to its plan and trust, as appropriate, to the same extent as the provisions apply to any entity TDI regulates under those provisions:

- (1) Chapter 1 of this title;
- (2) Chapter 3, Subchapter A of this title;

- (3) Chapter 3, Subchapter E of this title;
- (4) Chapter 3, Subchapter G of this title;
- (5) Chapter 3, Subchapter M of this title;
- (6) Chapter 3, Subchapter U of this title;
- (7) Section 3.3601 of this title;
- (8) Chapter 3, Subchapter V of this title;
- (9) Chapter 3, Subchapter X of this title;
- (10) Chapter 3, Subchapter BB of this title;
- (11) Chapter 3, Subchapter HH of this title;
- (12) Chapter 12 of this title;
- (13) Chapter 19, Subchapter R of this title;
- (14) Chapter 21, Subchapter A of this title;
- (15) Chapter 21, Subchapter B of this title;
- (16) Chapter 21, Subchapter C of this title;
- (17) Chapter 21, Subchapter E of this title;
- (18) Chapter 21, Subchapter H of this title;
- (19) Chapter 21, Subchapter K of this title;
- (20) Chapter 21, Subchapter L of this title;
- (21) Chapter 21, Subchapter M of this title;
- (22) Chapter 21, Subchapter P of this title;
- (23) Chapter 21, Subchapter Q of this title;
- (24) Chapter 21, Subchapter R of this title;

- (25) Chapter 21, Subchapter T of this title;
- (26) Chapter 21, Subchapter V of this title;
- (27) Chapter 21, Subchapter W of this title;
- (28) Chapter 21, Subchapter Y of this title;
- (29) Chapter 21, Subchapter Z of this title;
- (30) Chapter 21, Subchapter AA of this title;
- (31) Chapter 21, Subchapter BB of this title;
- (32) Chapter 21, Subchapter CC of this title;
- (33) Chapter 21, Subchapter DD of this title;
- (34) Chapter 21, Subchapter EE of this title;
- (35) Chapter 21, Subchapter FF of this title;
- (36) Chapter 21, Subchapter II of this title;
- (37) Chapter 21, Subchapter JJ of this title;
- (38) Chapter 21, Subchapter KK of this title;
- (39) Chapter 21, Subchapter MM of this title;
- (40) Chapter 21, Subchapter NN of this title;
- (41) Chapter 21, Subchapter PP of this title;
- (42) Chapter 21, Subchapter RR of this title;
- (43) Chapter 21, Subchapter SS of this title;
- (44) Chapter 22 of this title; and
- (45) Chapter 26 of this title.

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

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

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

(e) Approved PEO as large employer carrier; client as large employer. For purposes of applying §§26.303 and 26.307 - 26.309 of this title, an approved PEO is the equivalent of a large employer carrier, and the approved PEO's client is the equivalent of a large employer.

### **DIVISION 3. CERTIFICATE OF APPROVAL**

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

#### **§13.531. Forms and Fees.**

(a) Form of application. A PEO must apply for a certificate of approval in a format acceptable to TDI and provide the information required by this division.

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

**§13.532. Application Requirements.**

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

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

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

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

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

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

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

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

(6) disclosure of any suit or judgment filed in a matter involving dishonesty, breach of trust, or a financial dispute within the last 10 years against the applicant, the ultimate

controlling person, or any other persons from whom biographical information is provided in its application;

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

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

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

(B) an income statement;

(C) a cash flow statement; and

(D) the sources and uses of all funds;

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

(A) administer the plan; and

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

(10) evidence of the fidelity bond or crime policy that complies with §13.542;

and

(11) for all health benefit plans sponsored by the applicant, whether operating in this state or in any other state, access to all reports for the last three years created and filed with the United States Department of Labor in compliance with Sections 101(g), 103, and 104 of ERISA, 29 U.S.C. Sections 101(g) (Reporting By Certain Arrangements), 1023 (Annual Reports), and 1024 (Filing and Furnishing of Information).

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

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

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

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

(B) an income statement;

(C) a cash flow statement; and

(D) the sources and uses of all funds;

(3) a written investment plan in compliance with Insurance Code §425.105;

(4) an actuarial opinion supporting the structure of the plan meeting the requirements of §13.533 of this title;

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

(6) the name and Texas license number of all contracted regulated entities the trust proposes to engage to service the plan, and copies of the applicant's agreements or proposed agreements with those contracted regulated entities;

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

(A) the plan instrument;

(B) its summary plan description, created in compliance with Section 102 of ERISA, 29 U.S.C. Section 1022 (Summary Plan Description); and

(C) the trust instrument;

(8) the name of the named fiduciary or fiduciaries who jointly or severally will have authority to control and manage the operation and administration of the plan, as required by Section 402(a) of ERISA, 29 U.S.C. Section 1102(a) (Establishment of Plan);

(9) biographical information about each person who governs or manages the affairs of the applicant, accompanied by information sufficient to allow the commissioner to determine the competence, fitness, and reputation of each officer or director of the applicant or other controlling person, and including disclosure of whether the person is prohibited from serving in any capacity under Section 411, ERISA (29 U.S.C. Section 1111);

(10) a complete set of fingerprints for the individuals described in subsection (9) of this section using the procedures set out in Chapter 1, Subchapter D of this title, unless the individual meets the exemption in that subchapter or provides evidence that the individual has successfully completed the fingerprinting process conducted during the applicant's licensing or license renewal process through TDLR;

(11) evidence of the fidelity bond or crime policy and errors and omissions policy that comply with §13.556 of this title; and

(12) an attestation that the plan and trust have been established in compliance with §13.550 and §13.551 of this title.

(c) Officers' affidavit. An applicant must provide affidavits by two principal officers of the applicant who have submitted biographical affidavits that the information and documentation

provided in compliance with subsections (a) and (b) of this section is true and correct and complies with applicable federal and state laws and regulations, including this subchapter, to the best of their knowledge and belief.

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

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

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

(A) are not excessive;

(B) are not unfairly discriminatory;

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

(i) benefit payments;

(ii) administrative expenses;

(iii) other operational expenses; and

(D) are sufficient to maintain the required reserves and surplus to be held

in trust for the plan's participants; and

(2) include a statement of the costs to be charged to clients for plan coverage,

including an itemization of amounts for:

(A) the plan's administrative expenses;

(B) plan reserves; and

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

**§13.534. Application Review, Approval, and Denial.**

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

(1) conduct any investigation that the commissioner considers necessary to determine whether the applicant has within its own organization adequate facilities, resources, and competent personnel, as determined by the commissioner, to administer the plan and trust;

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

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

(b) Application approval. After completing the review the commissioner will approve an application for a certificate of approval that meets the requirements of §13.532 of this title.

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

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

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

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

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

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

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

(D) is prohibited from serving in any capacity under Section 411, ERISA (29 U.S.C. Section 1111);

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

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

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

or

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

(G) is not eligible for licensure under Chapter 1, Subchapter D of this title.

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

(f) Hearing on denial. If, within 30 days of receiving the commissioner's notice, the applicant submits a written request for a hearing, the commissioner will file a request to set a hearing at the State Office of Administrative Hearings, at which the applicant will be given an opportunity to show compliance with the related Insurance Code provisions and regulations.

Hearings described in this subchapter will be conducted as required by Government Code Chapter 2001, Insurance Code Chapter 36, TDI's rules of procedure, and any other applicable law and accompanying regulations.

#### **DIVISION 4. CONDUCT OF APPROVED PEO**

##### **§13.540. Governance and Operation of Approved PEO.**

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

(b) Initial plan administration. An approved PEO must have within its own organization adequate facilities and competent personnel to properly administer the plan and trust, or must contract with a third party administrator to provide those services, until the plan's trustees have selected a third party administrator, as provided in §13.555 of this title.

(c) Location of books and records. An approved PEO may request to maintain the plan and trust's books and records outside this state under Insurance Code Chapter 803, concerning Location of Books, Records, Accounts, and Offices Outside of This State.

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

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

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

(a) Contributions assessed by the approved PEO from clients for coverage for their participants must be sufficient to fund at least 100 percent of the plan and trust's aggregate stop-loss retention, as provided in Division 6, plus all other costs of the plan and trust.

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

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

- (1) establish and initially administer the plan and trust; and
- (2) comply with this subchapter, including contracting for stop-loss insurance and fidelity coverage.

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

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

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

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

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

**§13.544. Marketing Materials; Offers of Enrollment.**

(a) Marketing material. An approved PEO's marketing material discussing the plan and trust must be fair and accurate, and must not represent the plan or cost of coverage under the plan in a way that is materially inaccurate or misleading.

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

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

(1) for nonpayment of contributions;

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

(3) for noncompliance with material plan provisions;

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

(5) in the case of a plan that offers benefits through a network plan, there is no longer any individual enrolled through the client who lives, resides, or works in the service area

of the network plan and the plan applies this paragraph uniformly without regard to the claims experience of clients or any health status-related factor in relation to such individuals or their dependents; and

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

**§13.545. Representations to Clients and Participants.**

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

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

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

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

(e) Summary plan description. An approved PEO must provide each participant an evidence of coverage and a summary plan description specific to the participant's plan. The summary plan description must contain the following statement:

“The benefits and coverages described in this document are provided through a self-funded health benefit plan and trust fund established and funded by your employers, [insert the name of the covered employer and the approved PEO]. The plan and trust are established in compliance with Chapter 91 of the Texas Labor Code and ERISA (29 U.S.C. §§1001-1191c). This is not an insurance contract, and you are not protected by an insurance guarantee fund or other protective governmental program.”

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

##### **§13.550. Plan Formation.**

(a) Establishing the plan. The applicant must establish its plan in compliance with ERISA §402, 29 U.S.C. §1102 (Establishment of Plan).

(b) Required plan provisions. The plan:

(1) must be a nonprofit entity;

(2) must hold all plan assets in a trust as established in §13.551 of this title;

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

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

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

**§13.551. Trust Formation.**

(a) Establishing the trust. The applicant must establish a trust in compliance with both Texas Property Code Title 9, Subtitle B (Texas Trust Code: Creation, Operation, and Termination of Trusts) and ERISA §403, 29 U.S.C. §1103 (Establishment of Trust) in which all funds used to administer and pay claims arising from the plan must be held.

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

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

- (1) include the names of the persons creating the trust and the names and signatures of each of the initial trustees;
- (2) state that all plan assets will be kept continuously in a qualified financial institution;
- (3) outline the powers and duties of the board of trustees;
- (4) provide that board decisions must be made by at least a simple majority;
- (5) give the trustees exclusive authority and discretion to manage and control plan assets;
- (6) provide that the trustees will not be subject to the direction of a named fiduciary; and
- (7) provide that plan assets will never inure to the benefit of any employer and will be held for the exclusive purposes of providing benefits to plan participants and defraying reasonable expenses of administering the plan.

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

- (1) only the plan's trustees may amend the terms of the trust, and may do so without the approval of the approved PEO;
- (2) an amendment to the trust document must be approved by at least a majority of the trustees; and
- (3) a trust amendment must be submitted to TDI for review and approval by the commissioner before becoming effective.

**§13.552. Required Filings.**

(a) Plan and trust amendments. An approved PEO must file for prior approval by the commissioner in a format acceptable to TDI each amendment to the plan and trust's organizational documents. An amendment will not be effective until approved by the commissioner. The approved PEO's filing must include, as applicable:

- (1) a statement by the approved PEO certifying that, to the best of the signer's knowledge and belief, in adopting the plan amendment, the approved PEO, the plan, and the trust will remain in compliance with this subchapter and all applicable provisions of ERISA (29 U.S.C. §§1001-1191c); or
- (2) a statement by the plan's trustees certifying that, to the best of the trustees' knowledge and belief, in adopting the trust amendment the plan and the trust will remain in compliance with this subchapter and all applicable provisions of ERISA (29 U.S.C. §§1101-1191c).

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

**§13.553. Plan and Trust Governance and Operation.**

(a) Plan fiduciary. Except as otherwise provided in subsection (b), a person is a plan fiduciary to the extent that the person:

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

(2) renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of the plan, or has any authority or responsibility to do so; or

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

(b) If any money or other property of an employee benefit plan is invested in securities issued by an investment company registered under the Investment Company Act of 1940, that investment will not by itself cause the investment company or the company's investment advisor or principal underwriter to be deemed a fiduciary as defined in this section. Nothing in this subsection limits the duties imposed on the investment company, investment adviser, or principal underwriter by any other law.

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

(1) for the exclusive purpose of:

(A) providing benefits to participants; and

(B) defraying reasonable expenses of administering the plan;

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

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

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

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

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

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

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

(1) administration of the plan and trust; and

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

(f) Voluntary termination of trust. The trust agreement must provide for the distribution of plan assets on dissolution of the trust. The distribution of assets must be fair and equitable with respect to the contributors to the trust. On termination of the trust, its assets will be distributed as provided in the trust agreement after the commissioner has canceled the approved PEO's certificate of approval under Division 8 of this subchapter.

**§13.554. Board of Trustees.**

- (a) Members of the board of trustees may be appointed by the approved PEO.
- (b) The board of trustees must have no fewer than three members.
- (c) An owner, officer, or employee of a third party administrator who provides services to the approved PEO, or any other person who has received compensation from the plan or trust may not serve as a board member.

**§13.555. Trustees' Responsibility and Authority.**

- (a) Prudence. Members of the board of trustees must give the attention and exercise the vigilance, diligence, care, and skill that a prudent person would use in like or similar circumstances.
- (b) Responsible for operations and assets. Members of the board of trustees are responsible for all operations of the trust and must take all necessary precautions to safeguard plan assets.

(c) Contract for plan administration. Within 12 months of the establishment of the initial board of trustees, the board of trustees will contract with a third party administrator to administer the day-to-day affairs of the plan.

(d) Insure payment of claims. Within 12 months of the establishment of the initial board of trustees, the board of trustees, or an approved PEO acting as their agent, will contract for, and pay for with plan assets, a stop-loss insurance agreement in the name of and for the benefit of the plan and trust that complies with the requirements of §13.567 of this title, to insure payment of all claims arising under the terms of the plan.

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

(f) Service without compensation. A trustee serves without compensation except for actual and necessary expenses.

**§13.556. Protection of Plan and Trust Assets.**

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

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

and trust. The policy must be purchased by a company that satisfies the requirements of §13.568(a)(2) of this title. The cost of the policy will be paid from plan assets.

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

**§13.557. Disputes Arising Under the Plan or Trust.** Benefit claims or other disputes arising under an approved PEO's plan are subject to the Insurance Code, including utilization review and independent review under Insurance Code Chapters 4201 and 4202, and to resolution under state law in the same manner as are benefit claims or disputes arising under a large employer health benefit plan issued under Insurance Code Chapter 1501.

#### **DIVISION 6. FINANCIAL SOLVENCY REQUIREMENTS FOR PEO PLANS**

**§13.560. Annual and Quarterly Reserves.** An approved PEO plan trust must file annual and quarterly financial statements with TDI. The financial statements must report the trust's reserves as described below:

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

(2) the total claim distributions number used in subsection (a) is the amount of paid claims reduced by any amount either received or recoverable by the trust associated with the specific attachment point included in its stop-loss insurance agreement;

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

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

**§13.561. Authorized Investments.** The trust must invest its assets in compliance with Insurance Code Chapter 425, Subchapter C.

**§13.562. Deposit or Letter of Credit Required.**

(a) Initial deposit or letter of credit. Before its first year of operation, an approved PEO sponsoring a plan must establish a deposit of at least 25 percent of the attachment point of the aggregate limit included in the plan's stop-loss insurance agreement, or establish a letter of credit for that amount.

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

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

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

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

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

(B) 10 percent of the issuing qualified financial institution's net worth, provided that its net worth is in excess of \$25 million;

(2) bonds of this state;

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

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

**§13.564. Annual Recalculation; Changes to Deposit.**

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

(b) Changes to deposit. Changes to the deposit will be made as follows:

(1) any additional deposit funds required to maintain the deposit must meet the requirements of this subsection and must be accompanied by a completed security deposit report form number 120, a TDI form;

(2) if any deposit or portion of the deposit is to be released, the request for release must be accompanied by a withdrawal form number 121, a TDI form. If the commissioner approves the release, TDI's bond and securities officer will execute a release of any pledge, and the funds will be returned to the approved PEO;

(3) for any substitution of funds, the approved PEO must submit a completed security deposit report form number 120, a completed withdrawal form number 121, or a pledge

document on bank letterhead or a safekeeping receipt evidencing that the security is pledged to TDI;

(4) if the approved PEO wishes to request a release of all or part of the deposit because the deposit amount exceeds the amount calculated under §13.562(b) of this title, the approved PEO must provide supporting documentation that justifies the release including:

(A) reasons for the release;

(B) evidence satisfactory to the commissioner that the deposit amount exceeds the amount in subsection (b); and

(5) all interest income due on the deposit funds may be paid directly to the approved PEO by the bank.

**§13.565. Letter of Credit.**

(a) Requirements. Instead of a deposit, an approved PEO may maintain a letter of credit.

A letter of credit must comply with the following requirements:

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

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

TDI; and

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

(B) contain an issue date;

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

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

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

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

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

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

(1) have a schedule of periodic payments;

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

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

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

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

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

(b) Changes to letter of credit.

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

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

**§13.567. Stop-Loss Insurance.**

(a) An annual actuarial opinion required by this subchapter must state the recommended level of specific and aggregate stop-loss insurance that the plan and trust must maintain.

(b) The trustees, or an approved PEO acting on behalf of the trustees, must contract for stop-loss insurance in the name of and for the benefit of the plan and trust, as evidenced by a written commitment, binder, or policy for stop-loss insurance issued by an unaffiliated insurer authorized to do business in this state, which must include the following:

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

(2) provide both specific and aggregate coverage with an aggregate retention of no more than 125 percent of the amount of expected claims for the subsequent plan year and the specific retention amount as determined by the actuarial opinion required by §13.533 of this title;

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

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

(c) On written request, the commissioner may waive or reduce the requirement for aggregate stop-loss insurance on a determination that the interests of the clients and participants are adequately protected.

**§13.568. Fidelity Coverage.**

(a) Fidelity bond or crime policy. A fidelity bond or crime policy required by any section of this rule must be for an amount of at least \$500,000, but the commissioner, after due notice and opportunity for hearing to all interested parties and after consideration of the record, may require an amount in excess of \$500,000. The bond or policy must:

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

(2) be issued by an unaffiliated insurer that holds a certificate of authority in this state, and that is a corporate surety company that is an acceptable surety on Federal bonds under authority granted by the Secretary of the Treasury under 31 U.S. Code Chapter 93. If the commissioner determines, after reviewing information from the approved PEO or the plan and

trust's board of trustees, that a fidelity bond or a zero-deductible crime policy is not available from a qualified unaffiliated insurer that holds a certificate of authority in this state, the approved PEO or board of trustees may obtain a fidelity bond or a zero-deductible crime policy from a surplus lines agent in this state in compliance with Insurance Code Chapter 981, or from a corporate surety company which is an acceptable surety on Federal bonds under authority granted by the Secretary of the Treasury under 31 U.S. Code Chapter 93.

(b) Cash deposit. Instead of a fidelity bond or zero-deductible crime policy, the approved PEO or board of trustees may place on deposit with a qualified financial institution securities meeting the requirements of §13.564 of this title for the benefit of the commissioner. The deposit must be maintained in the amount and is subject to the same conditions required for fidelity coverage under this section. The deposit must be held for TDI's control and may not be withdrawn or substituted without the commissioner's approval.

#### **DIVISION 7. QUARTERLY AND ANNUAL FILINGS; EXAMINATIONS; HAZARDOUS CONDITIONS AND SOLVENCY**

##### **§13.570. Financial Filing Requirements.**

(a) Approved filing forms. An approved PEO must submit its quarterly and annual filings on forms approved by the commissioner.

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

- (1) the trustees; and
- (2) the approved PEO.

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

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

(A) the trustees; and

(B) the approved PEO; and

(2) an annual actuarial opinion prepared and certified by an actuary who is not an employee of the approved PEO, and who is a fellow of the Society of Actuaries, a member of the American Academy of Actuaries, or an enrolled actuary under the ERISA (29 U.S.C. Section 1001, *et seq.*). The annual actuarial opinion must include:

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

(B) a calculation of reserves as required by Division 6 of this subchapter; and

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

(3) Audited financial statements for the plan and trust must be filed annually by June 1 of each year and meet the requirements of Insurance Code Chapter 401 Subchapter A, concerning Independent Audit of Financial Statements and §7.88 of this title.

**§13.571. Annual Fee.** With its annual filings an approved PEO must pay to TDI an annual statement filing fee of \$500. This fee does not include the form filing fees required under §13.521(b) of this subtitle.

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

**§13.573. Hazardous Condition; Violations of Statute.**

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

- (1) assets to liability ratio less than 1:1;
- (2) negative financial position;
- (3) negative net income combined with negative retained earnings;
- (4) negative cash flow;
- (5) failing to maintain minimum reserves;
- (6) the trust failing to receive all monthly contributions paid by clients to the approved PEO;
- (7) transfers of funds between the trust and the approved PEO not authorized under the trust agreement; or
- (8) mismanagement by the third party administrator, trustees, or approved PEO that endanger the solvency or operations of the plan and trust.

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

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

(d) Order to correct deficiencies. If the commissioner determines that the approved PEO's plan and trust do not comply with this section or are found to be in hazardous condition, the commissioner may order the approved PEO to correct the deficiencies. The commissioner may take any action authorized by the Insurance Code and other applicable laws against the approved PEO and its plan and trust if the approved PEO does not initiate immediate corrective action.

#### **DIVISION 8. MARKET EXIT**

##### **§13.580. Withdrawal from Market.**

(a) Withdrawal plan. An approved PEO that undertakes of its own initiative or is required by TDI to terminate its health benefit plan must file a withdrawal plan for review by the commissioner prior to terminating the plan. The withdrawal plan must include:

- (1) the approved PEO's reasons for the withdrawal;
- (2) a timeline for withdrawal, including the date on which the approved PEO intends to complete the withdrawal process;
- (3) a copy of the proposed notice to be sent to client employers and plan participants giving them at least 90 days' notice of the plan's termination;

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

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

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

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

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

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

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

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

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

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

(d) Modification or denial of withdrawal plan. The commissioner may modify the approved PEO's filed withdrawal plan or may deny the filed withdrawal plan and take regulatory action under Insurance Code Chapters 404, 406, 441, 443, and all other applicable law if the

approved PEO is unable to meet its contractual and financial obligations in a solvent and fair manner.

(e) Notice of denial. If the commissioner denies the withdrawal plan, the commissioner will issue a written notice of denial to the approved PEO. The notice will state the basis for the denial.

(f) Hearing request. If within 30 days of receiving the commissioner's notice the approved PEO submits a written request for a hearing, the commissioner will file a request to set a hearing at the State Office of Administrative Hearings, at which the approved PEO will be given an opportunity to show compliance with this subchapter.

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

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

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

(c) Suspension of certificate of approval. From the time the commissioner receives notice that TDLR is contemplating taking action against an approved PEO's license, an approved PEO's certificate of approval may be suspended at the commissioner's discretion. If an approved PEO's license is suspended, it may not contract with a new client to allow enrollment of its employees in the plan while the certificate of approval is suspended. When the

commissioner receives satisfactory notice that all outstanding issues between TDLR and the approved PEO are resolved to TDLR's satisfaction, TDI will remove the suspension of the approved PEO's certificate of approval.

(d) Notice of TDLR action terminating license. An approved PEO must notify the commissioner through TDI's licensing section within 10 business days of receiving notice that TDLR has revoked its license. The approved PEO's notice to the commissioner must include:

- (1) a copy of TDLR's notice of termination; and
- (2) confirmation that the approved PEO will file a withdrawal plan within 30

days that complies with §13.580 of this subchapter.

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

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

(a) The commissioner may limit, suspend, or revoke an approved PEO's certificate of approval if the commissioner finds that the approved PEO or its plan or trust do not meet the requirements of applicable Insurance Code provisions or this subchapter.

(b) If the commissioner limits, suspends, or revokes a certificate of approval, the commissioner will issue a written notice of the action to the approved PEO. The notice will state the basis for the limitation, suspension, or revocation.

(c) If, within 30 days of receiving the commissioner's notice, the approved PEO plan sponsor submits a written request for a hearing, the commissioner will file a request to set a

hearing at the State Office of Administrative Hearings, at which the approved PEO plan sponsor will be given an opportunity to show compliance with this subchapter.