SUBCHAPTER F. PROFESSIONAL EMPLOYER ORGANIZATIONS SPONSORING SELF-FUNDED EMPLOYEE HEALTH BENEFIT PLANS §§13.510 - 13.593

DIVISION 1. PURPOSE AND DEFINITIONS

§13.510. Purpose. A professional employer organization (PEO) holding a license in good standing from the Texas Department of Licensing and Regulation (TDLR) may sponsor a self-funded employee health benefit plan (plan) in this state only after it receives its certificate of approval from the Texas Department of Insurance under Labor Code §91.0411.

§13.511. 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.

§13.512. Definitions. The following words and terms, when used in this subchapter, will mean, 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) Cash equivalent--Has an original maturity date of three months or less, and is readily convertible to known cash amounts.

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

(6) Coemployer--A PEO or a client employer that is a party to a coemployment relationship with a PEO.

(7) Coemployment relationship--A contractual relationship between a client employer 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.

(8) Commissioner--The commissioner of insurance.

(9) Controlling person--A person controls an entity 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 insurer that it is necessary or appropriate in the public interest or for the protection of the insurer's policyholders that the person be considered to control the insurer. 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 entity; or

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

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

(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) Large PEO plan--A plan:

(A) that has an enrollment of 5,000 participants or more;

(B) that the plan sponsor elects to be regulated as a large PEO plan; or

(C) that offers no service to its client employer other than employee enrollment in the plan.

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

(A) the PEO, its client employers and coemployees; and

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

(14) Participant--An individual enrolled in a plan.

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

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

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

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

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

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

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

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

(20) Small PEO plan--A plan that:

(A) has an enrollment of fewer than 5,000 participants;

(B) the plan sponsor has not elected to be regulated as a large PEO plan; and

(C) is not a plan sponsored by an approved PEO that offers as its sole service to clients employee enrollment in the plan.

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

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

(23) Third party administrator--A third party administrator that holds a certificate of authority under Insurance Code Chapter 4151.

(24) Trust--A trust established under Texas Property Code Title 9, Subtitle B, and Section 403 of the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. Section 1103).

(25) 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 section lists Insurance Code provisions that are necessary to augment and implement the regulation of a PEO-sponsored health benefit plan that is not fully insured.

(b) Provisions applicable to any entity. The following provisions of the Insurance Code are applicable to an approved PEO, or to a plan or trust, as appropriate, 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; Production of Records;

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

(3) Insurance Code §38.001, concerning Inquiries;

(4) Insurance Code Chapters 82, concerning Sanctions;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(21) Insurance Code Chapter 601, concerning Privacy;

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

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

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

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

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

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

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

(29) Insurance Code Chapter 848, concerning Health Care Collaboratives;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(49) 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;

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

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

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

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

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

(55) Insurance Code Chapter 1357, concerning Mastectomy;

(56) Insurance Code Chapter 1358, concerning Diabetes;

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

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

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

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

(61) Insurance Code Chapter 1367 Subchapter B, concerning Childhood Immunizations;

(62) Insurance Code Chapter 1367 Subchapter C, concerning Hearing Test;

(63) Insurance Code Chapter 1367 Subchapter D, concerning Child Craniofacial Abnormalities;

(64) Insurance Code Chapter 1367 Subchapter E, concerning Developmental Delays;

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

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

(67) Insurance Code Chapter 1370, concerning Certain Tests for Detection of Human Papilloma Virus and Cervical Cancer;

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

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

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

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

(72) Insurance Code Chapter 1451, Subchapter F, concerning Access to Obstetrical or Gynecological Care;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Client employer as plan sponsor. For purposes of applying Insurance Code Chapter 1215, a client employer 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 employer as group policyholder. For purposes of applying Insurance Code Chapter 1301, an approved PEO is the equivalent of an insurer and the approved PEO's client employer is the equivalent of a group policyholder.

(f) Approved PEO as entitled employer. For purposes of applying provisions addressing required offers of coverage in Insurance Code Title 8, Subtitle E, 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 large employer issuer; client employer 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 employer is the equivalent of an employer.

(h) Approved PEO as carrier; client employer 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 employer is the equivalent of a policyholder.

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

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

(b) Provisions applicable to any entity. The following provisions of the 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 HH of this title;

(11) Chapter 12, of this title;

(12) Chapter 19, Subchapter R of this title;

(13) Chapter 21, Subchapter A of this title;

(14) Chapter 21, Subchapter B of this title;

(15) Chapter 21, Subchapter C of this title;

(16) Chapter 21, Subchapter E of this title;

(17) Chapter 21, Subchapter H of this title;

(18) Chapter 21, Subchapter K of this title;

(19) Chapter 21, Subchapter L of this title;

(20) Chapter 21, Subchapter M of this title;

(21) Chapter 21, Subchapter P of this title;

(22) Chapter 21, Subchapter Q of this title;

(23) Chapter 21, Subchapter R of this title;

(24) Chapter 21, Subchapter T of this title;

(25) Chapter 21, Subchapter V of this title;

(26) Chapter 21, Subchapter W of this title;

(27) Chapter 21, Subchapter Y of this title;

(28) Chapter 21, Subchapter AA of this title;

(29) Chapter 21, Subchapter CC of this title;

(30) Chapter 21, Subchapter EE of this title;

(31) Chapter 21, Subchapter FF of this title;

(32) Chapter 21, Subchapter II of this title;

(33) Chapter 21, Subchapter JJ of this title;

(34) Chapter 21, Subchapter MM of this title;

(35) Chapter 21, Subchapter NN of this title;

(36) Chapter 21, Subchapter PP of this title;

(37) Chapter 21, Subchapter RR of this title;

(38) Chapter 22 of this title; and

(39) Chapter 26 of this title.

(c) 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 client employers.

(d) Approved PEO as insurer; client employer 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 employer is the equivalent of a group policyholder.

(e) Approved PEO as large employer carrier and large employer. Except as provided in subsection (f), 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.

(f) Approved PEO as large employer carrier; client employer 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 employer is the equivalent of a large employer.

§13.522. Applicability of Insurance Code Provisions to an Approved PEO, its Large PEO Plan, or Trust.

(a) Necessary Insurance Code provisions. Under Labor Code §91.0411, this section lists Insurance Code provisions that are necessary to augment and implement the regulation of an approved PEO sponsoring a large PEO plan that is not fully insured.

(b) Provisions applicable to any entity. In addition to the provisions specified by §§13.520 and 13.521 of this title, the following provisions of the Insurance Code are applicable to an approved PEO sponsoring a large PEO plan, or to its plan or trust, as appropriate, to the same extent as the provisions apply to any entity TDI regulates under those provisions:

(1) Insurance Code Chapter 38, Subchapter C, concerning Data Collection and Reporting Relating to HIV and AIDS;

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

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

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

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

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

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

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

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

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

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

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

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

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

(15) Insurance Code Chapter 1356, concerning Reconstructive Surgery Following Mastectomy;

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

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

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

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

(20) Insurance Code Chapter 1367, Subchapter A, concerning Newborn Children;

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

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

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

(c) Approved PEO as insurer; client employer as policyholder. For purposes of applying provisions addressing required offers of coverage in Insurance Code Chapter 558, Subchapter A, an approved PEO is the equivalent of an insurer and the approved PEO's client employer is the equivalent of a policyholder.

(d) Approved PEO as issuer; client employer 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 employer is the equivalent of a group contract holder.

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

(a) Necessary Administrative Code provisions. Under Labor Code §91.0411, this section lists Administrative Code provisions that are necessary to augment and implement the regulation of a large PEO plan that is not fully insured.

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

(1) Chapter 3, Subchapter BB of this title;

(2) Chapter 21, Subchapter V of this title;

(3) Chapter 21, Subchapter Z of this title;

(4) Chapter 21, Subchapter BB of this title;

(5) Chapter 21, Subchapter DD of this title;

(6) Chapter 21, Subchapter KK of this title; and

(7) Chapter 21, Subchapter SS of this title.

DIVISION 3. CERTIFICATE OF APPROVAL

§13.530. Certificate of Approval Required. A PEO may not sponsor a plan in Texas unless the PEO has received a certificate of approval issued under this subchapter and is operating its plan 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.

§13.531. Forms and Fees.

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

(b) Application forms for small and large PEO plans. TDI may provide different application forms for a certificate of approval for small and large PEO plans.

(c) 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 client employers, 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) 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);

(7) a complete set of fingerprints for the individuals described in subsection (6) 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;

(8) 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 all other persons from whom biographical information is provided in its application;

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

(10) a financial statement of the applicant PEO 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;

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

(12) an actuarial opinion supporting the structure of the plan meeting the requirements of §13.533;

(13) a description of the applicant's present or proposed plan to service plan billings, claims, and underwriting;

(14) 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;

(15) the name and Texas license number of any third party administrator the applicant proposes to engage on behalf of the trust to service the plan, and copies of the agreements or proposed agreements with third party administrators;

(16) a specific outline and description of the applicant's marketing efforts. The applicant must list the names of all individuals directly employed or to be employed by the applicant who solicit client employers or adjust claims if they are involved in marketing efforts, indicating the qualifications and credentials of the individuals; and

(17) for all benefit plans sponsored by the applicant, whether operating in Texas or in any other state, all reports for the last three years created and filed with the U.S. 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 5 or 6, as applicable.

(2) financial projections of the trust covering three full years of operation, 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;

(3) 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;

(4) 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);

(5) the names of the trustees of the trust;

(6) biographical affidavits for the trustees identified in the trust instrument;

(7) evidence of the fidelity bond or crime policy and errors and omissions policy that comply with §§13.541, 13.563, or 13.574, and 13.556 of this title, as applicable; and

(8) 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, 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 beneficiaries; and

(2) include a statement of the costs to be charged to client employers 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 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, the Insurance Code, 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, and investment functions must be eligible for licensure based on the guidelines established in Chapter 1, Subchapter D 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 trustees have selected a third party administrator, as provided in §13.555 of this subchapter.

(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.

§13.541. Fidelity Coverage. An approved PEO must maintain a fidelity bond or a zero deductible crime policy, issued by an unaffiliated authorized insurance company that:

(1) protects against acts of fraud or dishonesty in servicing or administering the plan;

(2) covers each person responsible for administering or handling plan assets, including the approved PEO, its directors, officers and employees, or any other individual responsible for servicing the plan; and

(3) complies with §13.564 or §13.574 of this title, as applicable.

§13.542. Approved PEO's Conduct With Respect to the Plan and Trust.

(a) Contributions assessed by the approved PEO from client employers for coverage for their enrolled participants must be sufficient to fund at least 100 percent of the plan's aggregate retention plus all other costs of the plan and trust.

(b) Payments to the trust. An approved PEO must transfer to the trust within two business days of receipt all payments by client employers that represent or are intended as contributions to the trust. 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 purchasing 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.

§13.543. Marketing Materials; Offers of Enrollment.

(a) Marketing material. An approved PEO's marketing material must be fair and accurate, and may 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:

(1) may not choose whether to offer enrollment in the plan to a prospective client employer based on the prospective client employer's claims history or its employees' health status related factors; and

(2) must provide a prospective client employer a good-faith estimate of the cost of coverage under the plan and an accurate and concise description of the basis on which the cost of coverage was calculated, including:

(A) anticipated claims and loss adjustment expenses; and

(B) any other expenses, services or items charged.

(c) Enrollment of small employer's employees. If an approved PEO enrolls plan participants employed by a client employer that meets the definition of "small employer" in

Insurance Code §1501.002, the approved PEO may not decline to enroll employees of any of the approved PEO's other client employers that meet that definition.

(d) Cancellation of agreement. An approved PEO may not cancel its client services agreement with a client employer because of health benefit claims made by plan participants employed by the client employer.

§13.544. Representations to Client Employers and Participants.

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

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

(c) 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.

(d) Evidence of coverage and 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, *et seq.*). This is not an insurance contract, and you are not protected by an insurance guarantee fund or other solvency protection arrangement."

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 Section 402 of ERISA, 29 U.S.C. Section 1102 (Establishment of Plan).

(b) Required plan provisions. The plan:

(1) must be a nonprofit entity;

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

(3) may not condition participation on a client employer'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 Section 403 of ERISA, 29 U.S.C. Section 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 the ERISA (29 U.S.C. Sections 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. Section 1001-1191c).

(b) Transactions between parties. Agreements and transactions between 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 section, an affiliate and a trust are each considered members of an insurance holding company system as described in Insurance Code §823.006.

§13.553. Plan and Trust Governance and Operation.

(a) Plan fiduciary. A person is a plan fiduciary to the extent that the person:

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

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

(c) 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.

(d) Plan and trust expenses. All expenses of the plan and trust must be paid from plan assets. Expenses include:

(1) administration of the plan and trust; and

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

(e) 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. Establishment of Board of Trustees.

(a) Composition of board of trustees.

(1) Members of the initial board of trustees may be appointed by the approved PEO.

(2) The board of trustees must have no fewer than four members.

(3) At least 75 percent of the board members must be plan participants.

(4) An owner, officer, or employee of the approved PEO or 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.

(b) Election of trustees.

(1) By the end of the plan's first year of operation, the board must hold an election of trustees, in which half of the appointed board members' positions will be filled by election. Half of the initial appointed board will remain as trustees until the following election, in which the remaining appointed board positions will be filled by election. In all following elections, one half of the board positions will be filled by election.

(2) Each board member will be elected for a term of at least two years.

(3) The client employers will elect at least 75 percent of the board members.

(4) Each client employer with employees participating in the plan:

(A) must be given one month's notice of each election of board members and the names and qualifications of the candidates;

(B) is entitled to an equal vote; and

(C) may vote either in person or by a written proxy signed by the client employer; but

(D) an owner, officer, or employee of the plan sponsor or of a third party administrator who provides services to the plan, or any other person who has received compensation from the plan may not serve as proxy for a client employer.

§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 with third party administrator. 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) Audit committee. The board of trustees must appoint an audit committee of which at least one member must be a client employer.

(e) 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; Insuring Payment of Claims.

(a) Errors and omissions insurance. The trustees must purchase an errors and omissions policy issued by an unaffiliated authorized insurance company to cover the performance of their duties to the plan and trust. The cost of the policy will be paid from plan assets.

(b) Ensuring existence of fidelity coverage. The trustees must annually require that the approved PEO provide them documentation that it has maintained and is maintaining in effect fidelity coverage that complies with §13.541 of this subchapter.

(c) Stop-loss insurance. The trustees must pay from plan assets the cost of a stop-loss policy bought by the approved PEO in compliance with the requirements of §13.564 or §13.575, as applicable, of this subchapter to insure payment of all claims arising under the terms of the plan.

§13.557. Disputes Arising Under the Plan or Trust. Subject to Insurance Code Chapters 4201 and 4202, an approved PEO must include in its plan a statement that:

(1) all disputes arising under the plan or trust will be subject to the jurisdiction of Texas state courts; and

(2) the approved PEO and the plan and trust waive any right to assert a claim or defense based on federal statute or common law with respect to all disputes arising under the plan or trust.

DIVISION 6. FINANCIAL SOLVENCY REQUIREMENTS FOR SMALL PEO PLANS

§13.560. Reserves. An approved PEO sponsoring a small PEO plan must maintain reserves in the plan's trust in an amount not less than the greater of 20 percent of the total estimated plan contributions in the preceding plan year or 20 percent of the total estimated plan contributions for the current plan year.

§13.561. Assets Supporting Reserves. An approved PEO sponsoring a small PEO plan must maintain in the plan's trust cash or cash equivalents as defined in §13.512 of this title in an

amount no less than the total required reserves as determined under §13.560 of this subtitle. Any assets in excess of the total amount of cash or cash equivalents may be invested in compliance with Insurance Code Chapter 425, Subchapter C.

§13.562. Deposit or Letter of Credit.

(a) Required before application. Before applying for a certificate of approval by the commissioner, a PEO must establish a deposit or letter of credit satisfying the requirements of this section.

(b) Maintaining deposit or letter of credit. An approved PEO sponsoring a small PEO plan must maintain a deposit or a letter of credit. The deposit must be held for TDI's control and may not be withdrawn or substituted without the commissioner's approval.

(c) Requirements for deposit. A deposit must be no less than 100 percent of retained reserves as defined and established in §13.560.

(1) The deposit must consist of funds in the form of lawful money of the United States, bonds of this state, bonds or other evidences of indebtedness of the United States or any of its agencies when the obligations are guaranteed as to principal and indebtedness of any counties or municipalities of this state, in the form of:

(A) certificates of deposit, which must be issued by a qualified financial institution. However, the amount of total deposits by the approved PEO in the qualified financial institution may not exceed the greater of:

(i) the limits of federal insurance coverage on the deposits; or

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

(B) bonds of this state, bonds or other evidences of indebtedness of the United States or any of its agencies when the obligations are guaranteed as to principal and interest by the United States, or bonds or other interest-bearing evidences of indebtedness of any counties or municipalities of this state.

(2) An approved PEO must annually determine the amount of deposit required to comply with the 100 percent retained liabilities requirement. The approved PEO must annually update the amount of the deposit not later than April 15, to comply with the 100 percent retained liabilities requirement, and:

(A) any additional deposit funds required to maintain the 100 percent retained liabilities requirement must be in funds as described in subsection (b)(1) of this section and must be accompanied by a completed security deposit report form number 120;

(B) 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. If the commissioner approves the release, the TDI bond and securities officer will execute a release of any pledge, and the funds will be returned to the approved PEO;

(C) for any substitution of funds, the approved PEO must submit a completed security deposit report form number 120, a completed withdrawal form number 121, a pledge document on bank letterhead or a safekeeping receipt evidencing that the security is pledged to TDI;

(D) if the approved PEO wishes to request a release of all or part of the deposit because the deposit amount exceeds the 100 percent retained liabilities requirement the approved PEO must provide supporting documentation that justifies the release including:

(i) reasons for the reasons for the release; and

(ii) evidence satisfactory to TDI that the deposit amount exceeds the 100 percent retained liabilities requirement; and

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

(d) Requirements for letter of credit. 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 and stipulate that the beneficiary is the commissioner and 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;

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

(D) 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;

(E) 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

(F) state that it is subject to and governed by either the laws of the State of Texas, 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 a qualified financial institution.

(3) The letter of credit must not:

(A) have a schedule of periodic payments;

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

(C) 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.

(4) 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.

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

(6) 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.

§13.563. Fidelity Coverage.

(a) Fidelity bond or crime policy. An approved PEO sponsoring a small PEO plan must maintain in force in its own name a fidelity bond on its officers and employees or a zero deductible crime policy in an amount equal to the greater of 10 percent of the contributions received by the approved PEO on behalf of the plan and trust or 10 percent of the plan benefits paid during the preceding calendar year; provided that the bond or policy is subject to a minimum amount of $10,000 and a maximum amount of $500,000.

(b) The fidelity bond or zero deductible crime policy must 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 an employee or officer of the approved PEO, acting alone or in concert with others, while employed or serving as an officer of the approved PEO.

(c) Source of policy. The fidelity bond or zero deductible crime policy must be issued by an unaffiliated insurer that holds a certificate of authority in this state. If the commissioner determines after reviewing information from the approved PEO that a fidelity bond or a zero deductible crime policy is not available from an unaffiliated insurer that holds a certificate of authority in this state, the approved PEO may obtain a fidelity bond or a zero deductible crime policy procured by a surplus lines resident agent in this state in compliance with Insurance Code Chapter 981.

(d) Alternative fidelity security. Instead of a fidelity bond or zero deductible crime policy, the approved PEO may deposit cash with the comptroller. The deposit must be maintained in the same amount and is subject to the same conditions required for fidelity coverage under this section.

§13.564. Stop-Loss Insurance.

(a) Recommended level. An annual actuarial opinion required by this subchapter must state the recommended level of specific and aggregate stop-loss insurance that an approved PEO sponsoring a small PEO plan must maintain to insure payment of all claims arising under the terms of the plan.

(b) Insurance purchased. An approved PEO must purchase stop-loss insurance as evidenced by a written commitment, binder, or policy for stop-loss insurance issued by an unaffiliated insurer authorized, eligible or registered to do business in this state, which must include the following:

(1) no less than 30 days' notice to the commissioner of any 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 §13.505 and §13.517 of this title; and

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

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

DIVISION 7. FINANCIAL SOLVENCY REQUIREMENTS FOR LARGE PEO PLANS

§13.570. Reserves. Reserves of an approved PEO sponsoring a large PEO plan are subject to the provisions of Texas Insurance Code Chapter 425, Subchapter B.

§13.571. Minimum Net Worth.

(a) Amount maintained in trust. An approved PEO sponsoring a large PEO plan must maintain a minimum net worth of no less than $1.5 million in the plan's trust; all the trust's operating capital must be in excess of the $1.5 million minimum net worth.

(b) Form of net worth. The minimum net worth required by this section may only consist of:

(1) money of the United States;

(2) bonds of this state;

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

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

§13.572. Authorized Investments. An approved PEO sponsoring a large PEO plan must invest assets in excess of the minimum net worth required by §13.571 of this title in compliance with Insurance Code Chapter 425, Subchapter C.

§13.573. Deposit or Letter of Credit.

(a) Initial deposit or letter of credit. For its first year of operation an approved PEO sponsoring a large PEO plan must maintain a deposit of at least $300,000, or a letter of credit for that amount.

(b) Continuing deposit or letter of credit. An approved PEO sponsoring a large PEO plan must maintain after its first year of operation a deposit or letter of credit of no less than 100 percent of retained reserves as defined and established in §13.570. The deposit must be held for TDI's control and may not be withdrawn or substituted without the commissioner's approval.

(c) Requirements for deposit. A deposit must consist of:

(1) funds in the form described in §13.571(b). These funds can take the form of:

(A) 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:

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

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

(B) bonds of this state, bonds or other evidences of indebtedness of the United States or any of its agencies when the principal and interest of those obligations are guaranteed by the United States, or bonds or other interest-bearing evidences of indebtedness of any counties or municipalities of this state.

(2) The approved PEO must annually determine the amount of deposit required to comply with the 100 percent retained liabilities requirement. The approved PEO must

annually update the amount of the deposit not later than April 15, to comply with the 100 percent retained liabilities requirement, and:

(A) any additional deposit funds required to maintain the 100 percent retained liabilities requirement must be in funds as described in subsection §13.571(b) of this section and must be accompanied by a completed security deposit report form number 120;

(B) 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. 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;

(C) for any substitution of funds, the approved PEO must submit a completed security deposit report form number 120, a completed withdrawal form number 121, a pledge document on bank letterhead or a safekeeping receipt evidencing that the security is pledged to TDI;

(D) if the approved PEO wishes to request a release of all or part of the deposit because the deposit amount exceeds the 100 percent retained liabilities requirement the approved PEO must provide supporting documentation that justifies the release including:

(i) reasons for the release; and

(ii) evidence satisfactory to TDI that the deposit amount exceeds the 100 percent retained liabilities requirement; and

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

(c) Letter of credit. 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 and stipulate that the beneficiary is the commissioner and 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;

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

(D) 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;

(E) 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

(F) state that it is subject to and governed by either the laws of the State of Texas, 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 a qualified financial institution.

(3) The letter of credit must not:

(A) have a schedule of periodic payments;

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

(C) 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.

(4) 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.

(5) 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.

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

§13.574. Fidelity Coverage.

(a) An approved PEO sponsoring a large PEO plan must maintain in force in its own name a fidelity bond on its officers and employees or a zero deductible crime policy in an amount of at least $100,000 or another amount ordered by the commissioner.

(b) The fidelity bond or zero deductible crime policy must be issued by an unaffiliated insurer that holds a certificate of authority in this state. If the commissioner determines after

reviewing information from the PEO that a fidelity bond or a zero deductible crime policy is not available from an unaffiliated insurer that holds a certificate of authority in this state, the large approved PEO may obtain a fidelity bond or a zero deductible crime policy procured by a surplus lines agent resident in this state in compliance with Insurance Code Chapter 981.

(c) The fidelity bond or zero deductible crime policy must 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 an employee or officer of the large approved PEO, acting alone or in concert with others, while employed or serving as an officer of the large approved PEO.

(d) Instead of a fidelity bond or zero deductible crime policy, the large approved PEO may deposit cash with the comptroller. The deposit must be maintained in the amount and is subject to the same conditions required for fidelity coverage under this section.

§13.575. 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 large approved PEO must maintain.

(b) A large approved PEO must purchase stop-loss insurance 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 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 §13.505 and §13.517 of this title; and

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

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

DIVISION 8. QUARTERLY AND ANNUAL FILINGS; EXAMINATIONS

§13.580. Financial Filing Requirements.

(a) Quarterly filings. An approved PEO must file on approved forms 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 two appropriate officers or agents of the approved PEO.

(b) Annual filings. An approved PEO must file on approved forms with the commissioner within 90 days of the end of the calendar year:

(1) an annual financial statement audited by a certified public accountant under Insurance Code Chapter 401, Subchapter A (Independent Audit of Financial Statements);

(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 with proper actuarial regard for known claims, paid and outstanding, a history of incurred but not reported claims, claims handling expenses, unearned premium, an estimate for bad debts, a trend factor, and a margin for error; and

(C) recommended loss reserves as described below:

(i) for a small PEO, the loss reserves the plan and trust must maintain under Division 6 of this subchapter; or

(ii) for a large PEO, the loss reserves the plan and trust must maintain under Division 7 of this subchapter;

(D) a recommended level of specific and aggregate stop-loss insurance the approved PEO should maintain; and

(3) evidence of the approved PEO's aggregate stop-loss policy insuring its payment of all participants' claims arising from the plan, in compliance with §13.564 or §13.575 of this subtitle, as applicable.

§13.581. Annual Fee. With its annual filings an approved PEO must pay to TDI an annual statement filing fee of $1,500. This fee does not include the form filing fees required under §13.521(b) of this subtitle.

§13.582. 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 chapters apply to domestic insurers licensed to transact the business of insurance in this state.

§13.583. 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 meet minimum net worth requirements;

(6) the trust failing to receive all monthly contributions paid by client employers 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 9. TRANSITION BETWEEN SMALL AND LARGE PEO PLAN STATUS; MARKET EXIT

§13.590. Transition of Certificate of Approval Between Small and Large PEO Plan Status.

(a) Within 30 days of a small PEO plan reaching 4,000 covered participants, the approved PEO must notify the commissioner in writing whether it intends to transition its small PEO plan to large PEO plan status and provide additional information or documentation as requested by TDI.

(b) Within 30 days of a small PEO plan reaching 4,500 covered participants, the approved PEO must apply in writing to transition its small PEO plan to large PEO plan status. The application for transition must:

(1) include all information and documentation required in an application for approval to sponsor a large PEO plan that was not already included in the PEO's original application for approval to sponsor a small PEO plan; and

(2) include all proposed plan and trust documents or amendments needed to bring the plan and trust into compliance with the requirements for a large PEO plan in Division 2.

(c) After reaching 4,500 covered participants, the approved PEO may not enroll additional client employers' employees in the small PEO plan unless and until TDI approves the application for transition.

(d) A small PEO plan may not have more than 5,000 covered participants before TDI has approved the PEO's application for transition.

(e) Within six months of receiving approval to transition, the approved PEO must:

(1) issue to client employers and participants amended plan documents approved by the commissioner; and

(2) begin operating the plan in compliance with all requirements applicable to large PEO plans.

(f) An approved PEO whose large PEO plan has fewer than 5,000 participants may but is not required to apply for approval to transition to a small PEO plan on a form prescribed by TDI.

§13.591. 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 client employers 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 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), the commissioner will approve a withdrawal plan that satisfies the requirements of subsections (a) and (b).

(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 the related Insurance Code provisions and regulations.

§13.592. 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 via 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 employer 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 that agency's satisfaction, TDI will reactivate 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 §13.591 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.

§13.593. 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 the related Insurance Code provisions and regulations.