SUBCHAPTER P. ADMINISTRATORS
28 TAC §§7.1601 – 7.1618

1. INTRODUCTION. The Commissioner of Insurance adopts new Subchapter P, §§7.1601 - 7.1618, concerning administrators. Section 7.1613 and §7.1616 are adopted with changes to the proposed text published in the December 5, 2008 issue of the *Texas Register* (33 TexReg 9904). Sections 7.1601 – 7.1612, 7.1614, 7.1615, 7.1617, and 7.1618 are adopted without changes.

2. REASONED JUSTIFICATION. The adopted new sections are necessary to implement House Bill (HB) 472, enacted by the 80th Legislature, Regular Session, effective September 1, 2007, which amends the Insurance Code Chapter 4151. Chapter 4151 regulates administrators as that term is defined in §4151.001 of the Insurance Code and §7.1602(1) of these rules. The adopted rules are necessary to implement the licensing, reporting, oversight, and contracting requirements of the Insurance Code Chapter 4151.

The Department is simultaneously adopting the repeal of existing §7.1601 (relating to Definitions); §7.1602 (relating to Forms Relating to Regulation and Exemption of Administrators under the Insurance Code, Article 21.07-6); §7.1603 (relating to Application for Certificate of Authority); §7.1604 (relating to Application Denial, Suspension, Cancellation, or Revocation); §7.1605 (relating to Application Procedures); §7.1606 (relating to Exemption from Department Licensing and Regulation for Certain Administrators); §7.1607 (relating to Identification and Reporting

Requirements for Certain Insurers and Health Maintenance Organizations); §7.1608 (relating to Fees); §7.1609 (relating to Prohibited Transactions); §7.1610 (relating to On-Site Visits); §7.1611 (relating to Cease and Desist Orders); §7.1612 (relating to Supplemental Information/Annual Report); §7.1613 (relating to Fidelity Bond); §7.1614 (relating to Maintenance Tax); §7.1615 (relating to Severability); §7.1616 (relating to Limited Certificate of Authority for Non-Texas-Licensed Third Party Administrators for Multi-Jurisdictional Impaired Insurance Companies Estate Administration); and §7.1617 (relating to School District Group Health Coverage Contracts). The adopted repeal of these sections is also published in this issue of the *Texas Register.* This adoption includes new sections to replace the repealed sections.

The Department held a stakeholder's meeting on October 18, 2007, to discuss implementation of HB 472 with interested parties and invited public input concerning implementation, including comments and questions pertaining to the adoption of new rules the Department anticipated proposing to implement HB 472. The Department posted a first informal working draft of the proposed new rules on the Department's internet website from November 26 to December 14, 2007, and invited public input. The Department received several written comments regarding the informal working draft of the proposed new rules. The Department made several revisions to the first informal working draft in response to the public input received and posted a second informal working draft of the proposed new rules on the Department's website from October 21 to October 27, 2008, and again invited public comment. The Department received several written comments regarding the second informal working draft of the proposed new rules. The Department also held a series of meetings with various interested

parties that expressed a desire to meet with the Department to provide input on the proposed new rules. As a result of the written comments provided by industry representatives on the two informal working drafts of the proposed rules and the series of discussions with the interested parties, the Department modified several sections of the informal working draft of the proposed new rules, including revisions to (i) narrow the scope and matters to be considered by insurers during required semi-annual reviews and on-site biennial audits of administrators; (ii) reduce the number of required semi-annual reviews and biennial on-site audits by providing that reviews and audits of administrator subcontractors are not required if certain conditions are met; (iii) reduce the number of required semi-annual reviews and biennial on-site audits by increasing the threshold that the requirement to perform the required reviews and audits is triggered based upon a minimum threshold of, in the aggregate, each administrator that administers benefits in Texas on behalf of the insurer for more than 100 certificate holders, injured employees, plan participants or policyholders; (iv) reduce the number of required operational reviews of administrators by providing that an on-site audit may count as one of the required annual operational reviews during the same fiscal year that the on-site audit is conducted; (v) reduce the number of administrators that are required to provide audited financial statements to the Department by clarifying that this requirement is triggered only for an administrator that receives at least $10 million in compensation for providing administrative services in Texas during the preceding calendar year; and (vi) increase the length of time that an administrator has to notify the Department in writing if an administrator's fidelity bond is cancelled and not replaced with new coverage effective concurrently upon the date of the cancellation or

termination. The new rules were formally published in the December 5, 2008 issue of the *Texas Register* (33 TexReg 9904). A public hearing on the rule proposal was held on January 21, 2009. In response to written comments on the published proposal and comments made at the hearing, the Department has changed some of the proposed language in the text of the rule as adopted. The changes, however, do not materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

As a result of comments, §7.1613(d)(1) as adopted is changed to require a written agreement entered into under §7.1613 to include a requirement that the administrator must comply with all statutory, contractual, and regulatory requirements related to a function assumed or carried out by the administrator and related to a plan for which the administrator performs or offers to perform administrative services. This change is in response to a commenter who objected to proposed §7.1613(d)(1). According to the commenter, proposed §7.1613(d)(1) requires written agreements to cite to compliance with specific Texas state laws, which would be onerous and impracticable in agreements that address services provided in numerous jurisdictions on a national basis. The commenter stated that agreements between insurers and administrators often contain general provisions that the administrator shall comply with all applicable laws and regulations. The commenter recommended that the requirement that the written agreements contain references to several specific Texas statutes be deleted, or if not deleted, then, the deadline for implementation of the written agreement provisions be extended until at least June 1, 2010. Though the Department disagrees with the recommended changes, the Department believes that its revisions to

§7.1613(d)(1) in the adoption address the commenter's concerns by giving insurers and administrators more flexibility in meeting the contract requirement in §7.1613(d)(1). Section 7.1613(d)(1) as adopted does not require written agreements to contain specific references to specific Texas statutes or regulations.

Also, as a result of comments, §7.1616(b) is changed as adopted to state that "Other facts and circumstances not specified in §7.1616(a), as determined by the commissioner, that relate to the financial condition or business operations or conduct of an applicant or administrator in this state may also indicate that an applicant or administrator is operating in a hazardous or injurious manner." This clarification is the result of three commenters objecting to proposed §7.1616(b). According to one commenter, proposed §7.1616(b) has a loophole to allow the Department to identify virtually any practice as "hazardous." This commenter recommended revising proposed §7.1616(b) to state "other activities similar in nature and effect to the activities identified in subsection (a)." A second commenter states that proposed §7.1616(b) is not specific enough about what may constitute "hazardous or injurious manner," and suggested revising proposed §7.1616 to be more specific, perhaps by cross-referencing the laundry list of improper acts contained in the Insurance Code §4151.301. A third commenter requested that proposed §7.1616(b) be deleted. This commenter objects to proposed §7.1616(b) as overly broad and over-reaching, and states that proposed §7.1616(b) does not specify the basis for determining that an applicant or administrator is operating in a hazardous or injurious manner. The Department declines to make the three commenters' suggested changes, in part, because the changes would negate the public policy benefits of providing regulatory guidance regarding compliance with the

Insurance Code §4151.301(8). However, as a result of the concerns expressed by the three commenters, the Department has determined that it is necessary to revise proposed §7.1616(b) for purposes of clarity. The Department believes that the revisions to §7.1616(b) as adopted address the commenters' concerns.

The following paragraphs generally discuss the significant changes to the Insurance Code Chapter 4151 as a result of HB 472. They also provide a brief summary as well as an analysis of the reasons for the adopted rules, which include licensing, reporting, oversight, and contracting requirements necessary to implement the Insurance Code Chapter 4151.

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

Adopted new §7.1601 specifies the scope and applicability of the adopted new rules. Adopted new §7.1601(a) provides that, except as otherwise provided by the Insurance Code Chapter 4151 or the new adopted rules, the rules apply to a person acting as or holding itself out as an administrator in any capacity. This applicability is regardless of whether the person holds another authorization pursuant to the Insurance Code or the Labor Code. The issue of whether a particular person is subject to the new subchapter depends entirely upon whether the person is acting as or holding itself out as an administrator, as that term is defined in adopted new §7.1602(1). Adopted new §7.1602(1) incorporates the statutory definition of the term administrator that is in the Insurance Code §4151.001(1). Section 4151.001(1) defines an administrator as a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. Further, §4151.001(1) provides that the term includes: (i) a delegated entity under the Insurance Code Chapter 1272; and (ii) a workers' compensation health care network authorized under the Insurance Code Chapter 1305 that administers a workers' compensation claim for an insurer, including an insurer that establishes or contracts with the network to provide health care services. Section 4151.001(1) specifies that the term does not include a person described by the Insurance Code §4151.002. Thus, in order to determine whether a person meets the definition of the term administrator in §7.1602(1), it is necessary to evaluate the functions or services that the person is: (i) performing or providing; or (ii) offering to perform or provide. If the person qualifies for a specific exemption in the Insurance Code §4151.002 or §4151.0021, the person is not

an administrator for the purpose of these rules. However, if the person does not qualify for one of these exemptions, and the person collects or offers to collect premiums or contributions from residents of this state or adjusts, settles, or offers to adjust or settle claims for residents of this state, in connection with annuities or life, health, accident, pharmacy, or workers' compensation benefits, the person meets the definition of administrator in the Insurance Code §4151.001(1) and new §7.1602(1). This is true, regardless of whether the person is also performing or providing other functions or services that subject the person to compliance with the Insurance Code and the Labor Code. Adopted new §7.1601(a) makes clear that a person acting as or holding itself out as an administrator may be simultaneously subject to the requirements of other provisions of the Insurance Code, the Labor Code, or rules adopted thereunder if the functions or services performed or offered by that person require such regulation. In such event, the person will be required to hold all appropriate authorizations pursuant to the Insurance Code or the Labor Code in order to perform or offer the regulated functions and services. This is because a single authorization issued pursuant to the Insurance Code or the Labor Code does not authorize a person to perform or offer any additional regulated functions or services than those specified by the authorization. Each authorization relates to specific functions or services regulated under specific Insurance Code or Labor Code provisions. Therefore, a person must hold the applicable authorizations in order to perform or offer the corresponding regulated functions or services. The following example is provided for illustrative purposes. A person holds an authorization pursuant to the Insurance Code to operate a workers' compensation network in this state under the Insurance Code Chapter 1305. The

person acts as or holds itself out as an administrator by settling a claim on behalf of the insurer that established or contracted with the network to provide health care services. In this example, the person will be simultaneously subject to the requirements of the Insurance Code Chapters 1305 and 4151 and the implementing rules for each chapter. The person will be required to hold a separate authorization under each of these chapters and be licensed as both a workers' compensation network and an administrator. This is because the authorization issued to the person under Chapter 1305 to operate a workers' compensation network in this state only authorizes the specific functions regulated under Chapter 1305. That specific authorization does not authorize the person to perform other activities that are regulated under other Insurance Code or Labor Code provisions. In order for the person to act as an administrator under the Insurance Code Chapter 4151, the person must hold a separate authorization issued pursuant to Chapter 4151. The person will be subject to the requirements of Chapter 1305 and the implementing rules for its functions related to operating a workers' compensation healthcare network. The person will also be simultaneously subject to the requirements of the Insurance Code Chapter 4151 and the implementing rules for acting as or holding itself out as an administrator. In order for the person to engage in each of these regulated activities, the person must hold separate authorizations issued under the applicable Insurance Code or Labor Code statutes and must comply with the rules adopted under each of those statutes. Adopted §7.1601(c) further reinforces this requirement by providing that an administrator must meet the requirements of the Insurance Code Chapter 4151 and the adopted new rules in addition to any other requirements that apply to that person as: (i) a delegated third

party of a health maintenance organization (HMO) under the Insurance Code Chapter 1272; (ii) a workers' compensation healthcare network under the Insurance Code Chapter 1305; (iii) a qualified claims servicing contractor under the Labor Code Chapter 407; or (iv) an administrator or service company under the Labor Code Chapter 407A.

Adopted new §7.1601(b) is necessary to effectuate the legislative intent of HB 472 by providing uniform application of the requirements of the Insurance Code Chapter 4151 to all administrators to which that chapter applies. As such, new §7.1601(b) requires an administrator performing administrative services on behalf of an HMO pursuant to the Insurance Code Chapter 1272 or a workers' compensation self-insurance group (group) pursuant to the Labor Code Chapter 407A to comply with the same requirements under the Insurance Code Chapter 4151 and the adopted new rules as an administrator performing administrative services on behalf of an insurer or plan sponsor. This will ensure that, to the extent possible, all administrators are treated equally under the Insurance Code Chapter 4151.

Adopted new §7.1601(d) makes clear that the new rules do not apply to a person acting as or holding itself out as an administrator for an ERISA (The Employee Retirement Income Security Act of 1974) qualified employee welfare benefit plan that is exempt from regulation by this state. However, this exemption only applies with respect to the particular employee welfare benefit plan the person is administering. The following two examples are offered for illustrative purposes. In the first example, a person acts as or holds itself out as an administrator for several ERISA qualified employee welfare benefit plans offered by self-insured employers. The person, however, does not act as or hold itself out as an administrator for any other entity.

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

Administrator Contractors and Administrator Subcontractors. The term administrator contractor is defined in adopted new §7.1602(3). The term administrator subcontractor is defined in adopted new §7.1602(4). An administrator contractor may choose to delegate some or all of its administrative functions to an administrator subcontractor. Neither the Insurance Code Chapter 4151 nor the adopted rules prohibit

the delegation of an administrative service from one administrator to another administrator. However, §7.1603(b) is necessary to clarify the responsibilities and obligations of an administrator contractor and an administrator subcontractor in situations where an administrative service is delegated from one administrator to another administrator, as the term administrator is defined in the Insurance Code §4151.001(1). Under adopted new §7.1603(b), both an administrator contractor and an administrator subcontractor are required to hold a certificate of authority under the Insurance Code Chapter 4151. This new requirement is necessary to ensure appropriate oversight of all administrators regulated under the Insurance Code Chapter 4151. The more times that a particular function is delegated from one administrator to another administrator, the greater the risk of non-performance or inadequate performance of that function. Additionally, because administrators are authorized under Chapter 4151 to: (i) collect premium and contributions from Texas residents; and (ii) adjust and settle claims for Texas residents, administrators often have access to and control of fiduciary bank accounts and other accounts designated for claims payment. While the authority of an administrator is largely determined by the particular person for which the administrator performs services, many administrators have great discretion in carrying out their delegated duties. Further, administrators often directly interact with Texas consumers, providers, physicians, staff members, and adjusters. Requiring all administrators, including administrator contractors and administrator subcontractors, to comply with the requirements of the Insurance Code Chapter 4151 and these rules will ensure appropriate oversight and more efficient regulation of all administrators. This should better protect the interests of the public and insurance consumers in this state.

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

Adopted new §7.1606 is necessary to prescribe notification requirements related to a change in control of an applicant or administrator. In order to clarify how the notification requirements apply to a change in control of an applicant or administrator, §7.1606(a) defines the meaning of term “control”; illustrates the manner in which control may be possessed; and describes when control exists for purposes of new §7.1606. Section 7.1606(b) requires an applicant or administrator to notify the Department in writing of a change of control in the ownership of the applicant or administrator within a specified time frame. The §7.1606(b) notice requirement is triggered when there is a change in the control of an applicant or administrator, including a change in any of the

circumstances specified in §7.1606(a). The additional guidance provided to applicants and administrators by §7.1606(a) should assist them in identifying reportable changes of control in their own organizations. Adopted new §7.1606(c) prohibits an applicant or administrator from filing the notification required by §7.1606(b) until a request for an acquisition of control has been approved under the Insurance Code §4151.211. This requirement is necessary to harmonize the provisions of the Insurance Code §4151.052(b) and §4151.211. Section 4151.052(b) requires an applicant or administrator to notify the Department of a change of control in the applicant's or administrator's ownership not later than the 30th day after the effective date of the change. However, §4151.211 prohibits a person from acquiring an ownership interest in an administrator unless the person has first filed specified information with the Department and the Department has approved the filed information. The harmonization in §7.1606(c) serves two important purposes. First, it provides the Department an opportunity to evaluate a requested acquisition of control of an applicant or administrator under the Insurance Code §4151.211 prior to the change taking place. The Department's review of a requested acquisition of control of an applicant or administrator is essential to ensure that the new acquisition does not impede the ability of the applicant or administrator to comply with the requirements of the Insurance Code Chapter 4151 or these rules. Further, it ensures that the proposed acquisition of control is appropriate and in the best interest of the public and the insurance consumers of this state. Adopted new §7.1606(c) also provides an opportunity to confirm whether an approved acquisition of control of an applicant or administrator actually occurs. This is necessary for the Department to remain informed of the significant changes in the

operations of the applicant or administrator. This should result in more effective regulation of the applicant or administrator.

Adopted new §7.1607 is necessary to emphasize the importance of reporting material changes in facts and circumstances to the Department and maintaining continued compliance with the requirements of the Insurance Code Chapter 4151 and the new rules. First, adopted new §7.1607(a) defines the phrase “material change in fact or circumstance.” It also provides a non-exhaustive list of examples of certain material changes in facts or circumstances that require notification to the Department under adopted new §7.1607(b) and (c). This sample list is provided to assist applicants and administrators in identifying specific changes in the facts or circumstances of their own organizations that require notification to the Department. Adopted new §7.1607(b) requires an administrator to notify the Department in writing of a material change in fact or circumstance within a specified time frame. This required notification is necessary to provide the Department with the opportunity to evaluate the reported change in order to determine its likely effect on the administrator. Further, if the reported change in fact or circumstance adversely reflects upon the integrity of the administrator, the Department must be able to take any necessary action as quickly as possible in order to prevent any injury to the public and insurance consumers of this state. Except as provided by §7.1606(b), §7.1607(c) requires an applicant to continually update the information filed in its initial application for a certificate of authority. This includes notifying the Department in writing of a material change in fact or circumstance, while the application is pending with the Department. This required notification is necessary to allow the Department to accurately assess an applicant's fitness for licensure. Further, if a

reported change in the information filed in an applicant's initial application for a certificate of authority prevents an applicant from fulfilling the minimum requirements necessary for the Department to approve its application, the Department must be able to identify and assess those situations quickly and accurately. Adopted new §7.1607(d) and (e) are necessary to address an applicant's or administrator's continued compliance with the requirements of the Insurance Code Chapter 4151 and these rules. Adopted new §7.1607(d) requires an applicant or administrator to meet the requirements of Chapter 4151 and these rules as those requirements apply to any material change in fact or circumstance identified by an administrator pursuant to §7.1607(b) and to any change in information identified by an applicant pursuant to §7.1606(c). Adopted new §7.1607(e) requires an applicant and an administrator to continuously maintain the qualifications necessary to obtain a certificate of authority under Chapter 4151. These new requirements ensure that an applicant and an administrator maintain the integrity of their organizations by meeting the minimum statutory and regulatory requirements applicable to their organizations at all times. This includes when certain facts and circumstances affecting those organizations change over time. Requiring all applicants and administrators to continually monitor their own organizations for compliance with applicable statutory and regulatory requirements will help ensure the financial health and integrity of the administrators in this state.

Adopted new §7.1609 is necessary to implement the annual reporting requirements of HB 472 and to clarify the Insurance Code §4151.205(f). Section 7.1609(a), (b), and (c) are necessary to prescribe the general requirements that apply to annual report filings under the Insurance Code §4151.205. Adopted new §7.1609(d) is

necessary to clarify the exemption provided by the Insurance Code §4151.205(f) and to establish the certification requirements prescribed by the Insurance Code §4151.205(f). HB 472 amends the Insurance Code §4151.205(a) to require an administrator to file an annual report with the Commissioner no later than June 30 each year. Pursuant to the Insurance Code §4151.205(a) - (d), the annual report must: (i) cover the preceding calendar year; (ii) include an audited financial statement performed by an independent public accountant; and (iii) include notes or attachments to the financial statement that reflect the complete name and address of each insurer in this state with which the administrator had an agreement during the preceding fiscal year. The Insurance Code §4151.205(f) exempts an administrator who meets certain conditions from filing the audited financial statement required by §4151.205(c). Section 4151.205(c) requires the exempted administrator to file a financial statement with the Commissioner, certified in the manner prescribed by Commissioner rule.

After the enactment of HB 472, the Department received inquiries regarding the applicability of the exemption allowed by the Insurance Code §4151.205(f). As a result, the Department is adopting new §7.1609(d)(1) to clarify that the exemption in the Insurance Code §4151.205(f) applies only to compensation received by an administrator for providing administrative services in Texas during the preceding calendar year. Thus, an administrator may qualify for the exemption in adopted new §7.1609(d)(1) if the administrator earns less than $10 million in compensation for providing administrative services in Texas, regardless of the amount of compensation the administrator earns for providing administrative services in other jurisdictions. Adopted new §7.1609(d)(1) is necessary to provide small administrators and

administrators with limited business in Texas the less costly option of filing a certified financial statement with the Department instead of an audited financial statement performed by an independent public accountant as part of their annual report. Of the 751 administrators currently licensed by the Department, the Department estimates that 734 may qualify for the exemption in adopted new §7.1609(d)(1) and may be eligible to utilize that option for the annual report filing due June 30, 2009. By providing a less costly filing option for these administrators, the Department anticipates that many of these administrators may be able to realize additional cost savings. Although §7.1609(d)(1) provides an exemption from the financial filing requirements of §7.1609(c) for certain qualifying administrators, the Department's ability to effectively regulate these qualifying administrators will not be negatively affected by the use of this exemption. In an effort to maintain effective regulation of these administrators and to ensure that all necessary financial information is timely filed with the Department, the Department is adopting new §7.1609(d)(2) and (3). Section 7.1609(d)(2) requires an administrator qualifying for the exemption in §7.1609(d)(1) to file an alternative financial statement with the Department that includes a certification form and is verified by at least two officers or other comparable responsible persons of the administrator. The certification form, Form Number FIN 490, Certification of Financial Statement, is adopted by reference in §7.1609(b)(1)(D); the form prescribes the text and format of the required certification. The §7.1609(d)(2) requirement is important for several reasons. First, it makes clear that no administrator is completely exempt from filing a financial statement with the Department. While compliance with the requirements of new §7.1609(d)(2) may be less costly or less onerous than compliance with the requirements of

§7.1609(c), an administrator qualifying for the exemption in §7.1609(d)(1) is nonetheless required to file a sufficient financial statement with the Department under §7.1609(d)(2). This minimum threshold enables the Department to exercise the necessary oversight over the financial health of an administrator qualifying for the exemption in §7.1609(d)(1). Second, §7.1609(d)(2) requires at least two officers or other comparable responsible persons of an administrator qualifying for the exemption to execute a notarized certification and to verify the financial statement filed with the Department. This requirement helps to ensure that the financial statements submitted to the Department are properly prepared, reviewed, and verified. Additionally, new §7.1609(d)(2) requires some involvement and oversight from the responsible persons of the administrator. This should result in more efficient management of the administrator. Further, adopted new §7.1609(d)(3) requires that an administrator qualifying for the exemption in new §7.1609(d)(1) meet all other requirements of new §7.1609. This requirement enables the Department to appropriately review the overall operating condition of an administrator, including its financial strength, claims payment history, account management, and compliance with applicable statutes, rules, and contract provisions, regardless of the type of financial statement filed by the administrator as part of its annual report. Adopted new §7.1609(e) provides that the Commissioner may request additional information as necessary to determine if an administrator is operating or conducting business in a potentially hazardous or injurious manner. This new requirement is necessary to enable the Department to earlier detect an administrator's potentially hazardous or injurious operating condition. HB 472 enacts §4151.301(8), which permits the Department to take appropriate action to address situations in which

an administrator is in a financial condition or is operating or conducting business in a manner that would render further transaction of business in this state hazardous or injurious to the public or insurance consumers of this state. The new requirement is important in ensuring that corrective actions can be taken at the earliest possible point in time to alleviate or prevent harm to the public and insurance consumers of this state as a result of an administrator's hazardous or injurious operating condition.

Oversight Requirements. While the use of administrators may provide insurers, HMOs, plan sponsors, and groups with cost savings and access to persons with specialized claims payment and management skills, it also presents special challenges. The authority of an administrator is largely determined by the particular insurer, HMO, plan sponsor, or group that has delegated duties to the administrator. As a result, many administrators are given wide discretion in carrying out their delegated duties. Depending upon each insurer's, HMO's, plan sponsor's, or group's individual preference, an administrator may perform a wide variety of statutorily required duties on behalf of the insurer, HMO, plan sponsor, or group. Administrators are often delegated the responsibility of timely paying medical benefits and workers' compensation benefits on behalf of insurers, HMOs, plan sponsors, and groups. Many administrators also have control over an insurer's, HMO's, plan sponsor's, or group's books and records and claims files. While such delegation of discretion may be appropriate in many instances, the monitoring and oversight of these administrators is essential in ensuring their compliance with applicable statutes, rules, and contract provisions for the functions they perform. New §§7.1611, 7.1612, 7.1615, and 7.1616 are adopted to address the monitoring and oversight of administrators.

First, §7.1611 is necessary to implement the review and on-site audit requirements of the Insurance Code §4151.1042. HB 472 enacts the Insurance Code §4151.1042, which requires an insurer to ensure competent administration of its programs. Further, the Insurance Code §4151.1042 requires an insurer to conduct a semi-annual review of the operations of each of its administrators that, on the insurer's behalf, administers benefits for more than 100 certificate holders, injured employees, plan participants, or policyholders. Additionally, the Insurance Code §4151.1042 requires an insurer to conduct a biennial on-site audit of the operations of each of its administrators that, on the insurer's behalf, administers benefits for more than 100 certificate holders, injured employees, plan participants, or policyholders. The new requirements of §7.1611 impose a minimal level of oversight and responsibility on each insurer that utilizes the services of an administrator. These new requirements are significant because an insurer retains the ultimate responsibility and accountability for each function it delegates to an administrator. Thus, it is imperative that an insurer appropriately monitor the activities of its administrators to ensure their compliance with the Insurance Code, the Labor Code, and rules adopted thereunder. An insurer's regular oversight over its administrators is important. Therefore, new §7.1611(a) requires an insurer, no less than two times each fiscal year, to review the operations of each of its administrators that, in the aggregate, administers benefits in Texas on its behalf for more than 100 certificate holders, injured employees, plan participants, or policyholders. Additionally, §7.1611(b) requires an insurer, no less than once every two fiscal years, to conduct an on-site audit of each of its administrators that, in the aggregate, administers benefits in Texas on its behalf for more than 100 certificate

holders, injured employees, plan participants, or policyholders. New §7.1611(d) and (e) prescribe the minimum information that an insurer must review during the required review or on-site audit. This includes a review of an administrator's compliance with the contract between the administrator and the insurer and the administrator's performance of claims adjudication and payment. The new requirements also require an insurer to develop a written summary of the objectives and scope of the review or on-site audit and a summary of the results of the review or on-site audit. Each summary must include a corrective action plan addressing any deficiencies found during the review or on-site audit. These new requirements are important for several reasons. First, reviewing the prescribed information should enable an insurer to better assess its ability to meet its obligations under the Insurance Code, Labor Code, and rules adopted thereunder. Additionally, it is anticipated that an insurer's regular review of the required information will enable the insurer to foresee potential financial problems or solvency issues at a much earlier date, so that corrective action can be taken immediately. Further, new §7.1611 emphasizes the importance of establishing performance goals for administrators and reviewing the performance of the administrators to determine if those goals are being met. By regularly monitoring and overseeing its administrators, an insurer should obtain a better idea of its own capabilities, strengths, and weaknesses. This should result in financially healthier insurers. Additionally, if an insurer already has an audit plan in place to oversee its administrators, it may already meet several of the new requirements. In these situations, an insurer must only ensure that its current audit plan is modified to address the new requirements that are not currently being addressed in its audit plan.

Administrative services are sometimes delegated from one administrator to another administrator. Neither the Insurance Code Chapter 4151 nor the adopted new subchapter prohibits such a re-delegation of administrative services. However, an insurer remains ultimately responsible for the performance of all of its delegated functions, regardless of whether those functions are performed by an administrator contractor or by an administrator subcontractor. As previously discussed in this adoption, in a situation where an administrator contractor further delegates the performance of its administrative functions to an administrator subcontractor, both the administrator contractor and the administrator subcontractor qualify as an administrator under adopted new §7.1602(1). In such situations, because the administrator contractor and the administrator subcontractor are both performing delegated functions on behalf of an insurer, it is necessary for the insurer to regularly monitor and oversee the activities of both the administrator contractor and the administrator subcontractor. An insurer remains responsible for monitoring and overseeing the activities of all of its administrators, including its administrator contractors and administrator subcontractors. However, it may be appropriate for the administrator contractor that delegates the performance of a specific function to an administrator subcontractor to oversee the performance of that administrator subcontractor on the insurer's behalf. Therefore, §7.1611(g) provides an insurer with the option of meeting the §7.1611 monitoring and oversight requirements for an administrator subcontractor by reviewing and auditing its administrator contractor only. However, an insurer may utilize this option only if two requirements are met. First, an administrator contractor must supply the insurer with all the necessary and relevant information relating to a particular administrator

subcontractor. Second, the information provided to the insurer by the administrator contractor must indicate that no evidence of material non-compliance by the administrator subcontractor exists. If these two requirements are met, an insurer may utilize the option provided by §7.1611(g). However, if these two requirements are not met, an insurer must review and audit each administrator subcontractor that does not meet the two requirements in accordance with the §7.1611 review and audit requirements for its administrator contractors. New §7.1611(g) serves two important purposes. First, the insurer is requiring its administrator contractors to take an active role in ensuring that each administrator subcontractor performs its delegated administrative functions professionally, competently, and in compliance with all applicable statutes, rules, and contract provisions. Second, the insurer may be able to realize the benefit of consolidating the review of all of its administrators. A consolidated review may result in cost savings for the insurer while still ensuring an appropriate level of oversight of all administrators.

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

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

The remaining provisions of §7.1612 are necessary to regulate other administrator activities related to fiduciary bank accounts. New §7.1612(f) requires an administrator to properly maintain detailed accounting records documenting all deposits and withdrawals from a fiduciary account. This requirement ensures that each collected premium is properly accounted for and transferred to the appropriate insurer, HMO, plan sponsor, or group. New §7.1612(g) requires an administrator to provide a copy of the records relating to the account activity of an insurer, HMO, plan sponsor, or group in a fiduciary bank account to the insurer, HMO, plan sponsor, or group, upon its reasonable request. This requirement is necessary to provide an insurer, HMO, plan sponsor, or group with continuing access to a fiduciary account maintained by an administrator on

its behalf. This enables the insurer, HMO, plan sponsor, or group to properly oversee the activities of the administrator and to ensure that the premiums collected on its behalf are properly accounted for and maintained. Finally, new §7.1612(i) prohibits an administrator from paying a claim from a fiduciary bank account; this prohibition is consistent with the statutory prohibition in the Insurance Code §4151.109. It further ensures that all collected premiums are maintained in fiduciary accounts that are separate and distinguishable from any account used by an administrator to pay a claim on behalf of an insurer, HMO, plan sponsor, or group.

Depending upon the duties that an administrator performs on behalf of an insurer, HMO, plan sponsor, or group, an administrator may have access to, or control over, the books and records of an insurer, HMO, plan sponsor, or group. In such situations, it is necessary for the insurer, HMO, plan sponsor, or group to have continuing access to its books and records, even while the books and records are in the possession of an administrator. The Department is aware of situations in which administrators have refused to timely return the books and records of an insurer or have denied an insurer access to its own books and records altogether. These situations typically involved an insurer that terminated the employment of one administrator in order to employ the services of another administrator. These situations also usually occurred when there was an inadequate written agreement between the parties, or where the written agreement between the parties did not sufficiently address transition and ownership issues. An administrator's refusal to provide an insurer, HMO, plan sponsor, or group with access to its own books and records can have widespread and disastrous results, especially with regard to the payment of claims. An insurer, HMO,

plan sponsor, or group simply cannot comply with the requirements of the Insurance Code, the Labor Code, and rules adopted thereunder without knowing which of its claims have been paid and which of its claims remain outstanding. Additionally, an insurer, HMO, plan sponsor, or group may be put into a potentially hazardous financial condition if it is unable to access its financial books and records. New §7.1615 is adopted in an effort to prevent these situations from occurring. It addresses the continuity of services and ownership of books and records. Further, new §7.1615 is necessary to implement the Insurance Code §4151.103(d). Section 4151.103(d) provides that the Commissioner shall adopt rules to address the transfer of records from one administrator to another. The new requirements are also necessary to ensure that an insurer, HMO, plan sponsor, or group retains continual access to its own books and records following the termination of its relationship with an administrator. First, new §7.1615(a) requires an administrator to provide a complete and accurate original set or a complete and accurate copy or image of the original set of an insurer's, HMO's, plan sponsor's, or group's books and records to a successor administrator. If there is not a successor administrator or the successor administrator is unknown at the time of the required transfer, then they must be provided to the insurer, HMO, plan sponsor, or group. In both cases, the books and records must be provided no later than 30 days from the date of the termination of the relationship or written agreement between the insurer, HMO, plan sponsor, or group and the administrator, unless otherwise approved by the Commissioner. New §7.1615(b) requires the books and records to be transferred in an organized and usable manner. These new requirements are designed to prevent potentially hazardous financial conditions from occurring during transition

periods and to alleviate delays in claims payments. New §7.1615(d) requires an administrator to provide written notice to the Department of the termination of a relationship or written agreement with an insurer, HMO, plan sponsor, or group no later than 30 days from the date the administrator first learns of the termination. This new requirement provides the Department with the opportunity to monitor specific transition periods to ensure that claims are timely paid, premiums are appropriately collected and transferred, and the financial condition of insurers, HMOs, plan sponsors, groups, and administrators remain stable. New §7.1615(e) is necessary to address situations in which an administrator contractor has further delegated the performance of its administrative duties to an administrator subcontractor. In these situations, it is likely that the administrator contractor will have provided the administrator subcontractor with a portion of the books and records of the insurer, HMO, plan sponsor, or group so that the administrator subcontractor may appropriately perform its delegated duties. As previously discussed in this adoption, in a situation where an administrator contractor further delegates the performance of its administrative functions to an administrator subcontractor, both the administrator contractor and the administrator subcontractor qualify as an administrator under §7.1602(1). As such, the requirements of new §7.1615 apply equally to the administrator contractor and the administrator subcontractor. However, the termination of the relationship between an administrator contractor and an administrator subcontractor may not necessarily affect the relationship between the administrator contractor and the insurer, HMO, plan sponsor, or group. In such situations, it may be appropriate for the administrator contractor to retain its relationship with the insurer, HMO, plan sponsor, or group and to re-delegate

the performance of certain delegated functions to a new administrator subcontractor. Therefore, when an administrator subcontractor's relationship or written agreement with an administrator contractor terminates, new §7.1615(e) provides the administrator subcontractor with an option. The administrator subcontractor may comply with the requirements of new §7.1615 by providing a complete and accurate original set or a complete and accurate copy or image of the original set of the insurer's, HMO's, plan sponsor's, or group's books and records to the administrator contractor. The administrator subcontractor must also provide written notice to the Department of the termination of the relationship or written agreement with the administrator contractor, no later than 30 days from the date the administrator subcontractor first learns of the termination. This requirement serves two important purposes. First, it ensures that the administrator contractor maintains possession over the books and records that were originally provided to the administrator subcontractor on behalf of the insurer, HMO, plan sponsor, or group. Second, it allows the administrator contractor the opportunity to re-delegate the performance of certain delegated functions to another administrator subcontractor, should it choose to do so. Should an administrator subcontractor choose not to utilize the option provided by §7.1615(e), then that administrator subcontractor is required to meet the requirements of §7.1615 in the same manner that an administrator contractor is required to meet the requirements of §7.1615.

Finally, adopted new §7.1616 addresses circumstances that may indicate that an applicant or administrator is operating in a potentially hazardous or injurious manner. HB 472 enacts the Insurance Code §4151.301(8). This statute permits the Department to take appropriate action if an applicant or administrator is in a financial condition or is

operating or conducting business in a manner that would render further transaction of business in this state hazardous or injurious to the public or insurance consumers of this state. The new requirements are important in identifying applicants' and administrators' potentially hazardous or injurious conditions so that corrective actions, if necessary, may be taken at the earliest point in time to alleviate or prevent harm to the public and insurance consumers of this state. New §7.1616(a) provides eight illustrative examples of conduct that may indicate that an applicant or administrator is operating or conducting business in a potentially hazardous or injurious manner. These examples, however, are not exhaustive. New §7.1616(b) makes clear that the Commissioner may consider other factors and conditions, as determined by the Commissioner, that relate to the financial condition or business operations or conduct of an applicant or administrator in this state that are not specified in the eight examples to determine whether an applicant or administrator is operating in a potentially hazardous or injurious manner. Any of the specified factors or conditions in new §7.1616(a) and any of the factors or conditions determined by the Commissioner pursuant to new §7.1616(b) may be a basis for the Commissioner to initiate regulatory action against an administrator or applicant under the Insurance Code. However, the factors and conditions specified in new §7.1616(a) and new §7.1616(b) do not necessarily indicate that an applicant or administrator is operating in a potentially hazardous or injurious manner. Rather, they are factors and conditions that may be considered by the Department in determining whether an applicant or administrator is operating in a potentially hazardous or injurious manner. Also, in evaluating any of these factors or conditions, all circumstances concerning the administrator’s or applicant’s condition, activities, and operations must

be evaluated in order to determine whether an administrator or applicant is operating or conducting business in a potentially hazardous or injurious manner. For example, if an applicant or an administrator fails to file a financial statement with the Department as illustrated in new §7.1616(a)(1), the Department may contact the applicant or administrator and request additional information. Based upon the applicant's or administrator's response to the Department, the Department may further investigate the situation to determine if any preventative or correction action is needed or the Department may determine that the issue has been resolved. A final determination of whether an applicant or administrator is operating in a potentially hazardous or injurious manner may depend upon many factors and conditions, including one or more factors or conditions enumerated in §7.1616. However, a final determination of whether an applicant or administrator is operating in a potentially hazardous or injurious manner is not necessarily dependent upon a factor or condition enumerated in §7.1616. Section 7.1616 is intended to provide applicants and administrators guidance in managing their own organizations. By providing applicants and administrators with illustrative examples of situations that may constitute or lead to potentially hazardous or injurious operating conditions, the Department anticipates that applicants and administrators will take preventative steps to avoid these types of situations. This should result in financially healthier and more stable applicants and administrators.

Contracting Requirements. Because an insurer retains ultimate responsibility and accountability for the functions performed by its administrators, it is imperative that each insurer monitor the activities of its administrators and maintain appropriate oversight over its administrators. Therefore, adopted §7.1613 is necessary to establish

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

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

the duties performed by the administrator subcontractor are limited in scope. Because of the insurer-administrator contractor written agreement required under §7.1613(a), the insurer will be able to oversee the administrator contractor and monitor its activities. Further, new §7.1613(b) will enable the administrator contractor to oversee and monitor the performance of each of its administrator subcontractors through the written agreement that the administrator contractor has with each administrator subcontractor. This approach is intended to ensure that each administrator, whether an administrator contractor or an administrator subcontractor, is properly monitored by another responsible person. Should an administrator subcontractor choose not to utilize the option provided by new §7.1613(b), then that administrator subcontractor is required to meet the requirements of new §7.1613 in the same manner that an administrator contractor is required to meet the requirements of new §7.1613.

Application, Annual Report, and Exam Fees. New §7.1604(b)(2) adopts a non-refundable application filing fee of $1,000. The Insurance Code §4151.206(a)(1) provides that an applicant or administrator shall pay, in an amount to be determined by the Commissioner, a filing fee not to exceed $1,000 for processing an original application for a certificate of authority. The Department has determined that the new application fee amount is appropriate and necessary for the following reasons: (i) the new application fee amount is needed to offset the Department's costs for processing and reviewing administrator applications, including the new applications that will be required annually as a result of HB 472; (ii) the Department has not increased the current application fee amount since 1990, although the Department's responsibilities for the general administration of Chapter 4151 and the costs for reviewing and

processing administrator applications have increased since that time; and (iii) the new application fee amount is more consistent with other fee amounts charged by the Department for reviewing and processing other similar applications and issuing other authorizations.

New §7.1609(b)(2) adopts a non-refundable annual report filing fee of $200. This fee must accompany the annual report required to be filed by the administrator no later than June 30 each year. The Insurance Code §4151.206(a)(3) provides that an administrator shall pay, in an amount to be determined by the Commissioner, a filing fee not to exceed $200 for an annual report. The Department has determined that the $200 annual report fee amount is appropriate and necessary for the following reasons: (i) the new annual report fee amount is needed to offset the Department's costs for processing and reviewing administrator annual reports, including the new reports that will be required annually as a result of HB 472; (ii) the Department has not increased the current annual report fee amount since 1990, although the Department's responsibilities for the general administration of Chapter 4151 and the Department's costs for reviewing and processing administrator annual reports have increased since that time; and (iii) the new annual report fee amount is more consistent with other fees charged by the Department for reviewing and processing other entity's annual reports.

New §7.1617(a) adopts a non-refundable examination fee of $500, as authorized by the Insurance Code §4151.206(a)(2). The Insurance Code §4151.206(a)(2) provides that an administrator shall pay, in an amount to be determined by the Commissioner, a fee not to exceed $500 for an examination under the Insurance Code §4151.201. The Department has determined that the $500 fee is appropriate and necessary for the

following reasons: (i) the new exam fee amount is needed to offset the Department's costs for examining an administrator, including workers' compensation administrators that are now subject to examination under Chapter 4151; (ii) the Department has not increased the current exam fee amount since 1990, although the Department's costs for examining an administrator are likely to exceed that fee amount; and (iii) the new exam fee amount is still substantially less than other examination fees charged by the Department for conducting examinations of other entities.

Financial Statements under the Education Code. Section 7.1610 is necessary to implement the Education Code §22.004(h), concerning audited financial statements. The new section does not implement any new requirements resulting from the enactment of HB 472. The new section replaces existing §7.1617, relating to School District Group Health Coverage Contracts. The Department simultaneously is adopting the repeal of existing §7.1617, which also was published in the December 5, 2008 issue of the *Texas Register.* The Education Code §22.004(h) provides that an audited financial statement provided under §22.004 must be made in accordance with rules adopted by the Commissioner of Insurance or with generally accepted accounting principles, as applicable. The Education Code §22.004(g) provides that an insurer, a group hospital service corporation, or a health maintenance organization that issues a policy or contract under the Education Code §22.004 and any person that assists the school district in obtaining or managing the policy or contract for compensation shall provide an annual audited financial statement to the school district showing the financial condition of the insurer, group hospital service corporation, organization, or person. Section 7.1610(a) is necessary to specify that the section applies only to an insurer or

HMO that: (i) meets the requirements of §7.1605 (relating to Notification Requirements); and (ii) is subject to the requirements of the Education Code §22.004(g). Section 7.1610(b) is necessary to specify how an administrator meeting the requirements of §7.1610(a) may comply with the requirement for an audited financial statement under the Education Code §22.004(h).

3. HOW THE SECTIONS WILL FUNCTION.

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

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

§7.1602. Definitions. Adopted new §7.1602 defines the terms used in the adopted new subchapter.

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

§7.1604. Application for Certificate of Authority. Adopted new §7.1604(a) requires an applicant for a certificate of authority under Chapter 4151 to file an application with the Department, accompanied by a non-refundable fee of $1,000. New §7.1604(a) also requires the applicant to verify the application by attesting to the truth and accuracy of the information in the application. New §7.1604(b)(1) adopts by reference the following forms, which comprise the application for a certificate of authority under the Insurance Code Chapter 4151. These forms are available at www.tdi.state.tx.us/forms/form5tpa.html: (i) Form Number FIN 489, Application for a Certificate of Authority; (ii) Form Number FIN 306, Officers and Directors; (iii) Form Number LHL 081, Biographical Affidavit; and (iv) Form Number LHL 082, Service of Process. New §7.1604(b)(2) specifies that as authorized by the Insurance Code §4151.206(a)(1), the Commissioner adopts a filing fee of $1,000 to be paid by an applicant for processing an original application for a certificate of authority for an

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

§7.1605. Notification Requirements. Adopted new §7.1605(a) specifies that an insurer or HMO that is acting as or holding itself out as an administrator and that is

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

§7.1606. Requirements Related to Ownership Interest and Change of Control. The provisions of adopted new §7.1606(a)(1) - (3) relate to a change in the control of an applicant or administrator. The three provisions are for purposes of new §7.1606 only and for no other purposes. Adopted new §7.1606(a)(1) provides that control means the power to direct, or cause the direction of, the management and policies of a person, other than the power that results from an official position with or corporate office held by the person. Adopted new §7.1606(a)(2) provides that control may be possessed by various means, including through ownership of voting securities, ownership by contract, or direct or indirect control of one or more persons that control an administrator. Adopted new §7.1606(a)(3) provides that control exists if an individual or a member of an individual's immediate family, directly or indirectly, owns, controls, or holds with the power to vote 10 percent or more of the voting securities or authority of

an administrator or another person that directly or indirectly controls an administrator, including when a person holds proxies representing 10 percent or more of the voting securities or authority of the person. Pursuant to the Insurance Code §4151.052(b), adopted new §7.1606(b) requires an applicant or an administrator to notify the Department in writing of a change of control in the ownership of the applicant or the administrator not later than the 30th day after the effective date of the change. The §7.1606(b) notice requirement applies to any instance in which there is a change in the control of an applicant or administrator, including a change in any of the circumstances specified in §7.1606(a). Adopted new §7.1606(c) provides that an applicant or administrator may not file the §7.1606(b) notification until a proposed acquisition of control has been approved under the Insurance Code §4151.211.

§7.1607. Facts and Circumstances Affecting Issuance of Certificate of Authority. Adopted new §7.1607(a) defines the phrase “material change in fact or circumstance.” The phrase is defined as any fact or circumstance that impacts the accuracy or completeness of the information filed in an applicant's or administrator's initial application for a certificate of authority under the Insurance Code Chapter 4151. It includes: (i) a change in an applicant's or administrator's mailing address; (ii) a felony conviction of any executive officer or other comparable responsible person of an applicant or administrator or of any other person who directly or indirectly controls the applicant or administrator; and (iii) any administrative action, order, or judgment issued against an applicant or administrator. Adopted new §7.1607(b) requires an administrator to notify the Department in writing of a material change in fact or circumstance not later than the 30th day from the date the administrator first becomes

aware of the material change in fact or circumstance. Except as provided by new §7.1606(b) (relating to Requirements Related to Ownership Interest and Change of Control), new §7.1607(c) requires an applicant to continually update the information filed in its initial application for a certificate of authority under the Insurance Code Chapter 4151 while the application is pending with the Department. This includes notifying the Department in writing of a material change in fact or circumstance. Adopted new §7.1607(d) requires an applicant or administrator to meet the requirements of the Insurance Code Chapter 4151 and the new subchapter as those requirements apply to any material change of fact or circumstance identified by an administrator or any change in information identified by an applicant. Finally, new §7.1607(e) requires an applicant or an administrator to maintain the qualifications necessary to obtain a certificate of authority under Chapter 4151 at all times.

§7.1608. Fidelity Bond. Adopted new §7.1608(a) requires an applicant to obtain and an administrator to maintain a fidelity bond that complies with the requirements of the Insurance Code §4151.055 and new §7.1608. Adopted §7.1608(b) specifies that an applicant and an administrator may only obtain a fidelity bond from a surety company authorized to engage in business in this state as a surety or an eligible surplus lines insurer in compliance with the Insurance Code Chapter 981 and rules adopted thereunder. Adopted new §7.1608(c) requires an applicant or an administrator to immediately inform the Commissioner in writing if its fidelity bond is cancelled or terminated and not replaced with new coverage. The new coverage must meet the requirements of the Insurance Code §4151.055 and new §7.1608 and be effective concurrently upon the date of the cancellation or termination. Finally, adopted new

§7.1608(c) specifies that the required notification to the Commissioner must be given no later than ten business days from the date the applicant or the administrator first becomes aware of the cancellation or termination.

§7.1609. Annual Report. Adopted new §7.1609(a) requires an administrator to file an annual report with the Department no later than June 30 each year, accompanied by a non-refundable fee of $200. Adopted new §7.1609(b) adopts by reference the following forms: (i) Form Number FIN 486, Annual Report Form for Administrators Holding a Certificate of Authority under TIC 4151; (ii) Form Number FIN 487, Annual Report Form for Insurers and HMOs Subject to 28 TAC §7.1605; (iii) Form Number FIN 488, Annual Report Exhibits A-E; and (iv) Form Number 490, Certification of Financial Statement. These forms are available at www.tdi.state.tx.us/forms/form5tpa.html. Adopted new §7.1609(c) specifies that the annual report required by new §7.1609(a) must also include an audit report on the financial statements prepared by an independent certified public accountant that reflects an audit conducted in accordance with generally accepted auditing standards or with the standards adopted by the Public Company Accounting Oversight Board, as applicable. It must also include a balance sheet, an income statement, a cash flow statement, and a statement of equity. Adopted new §7.1609(d)(1) exempts an administrator receiving less than $10 million in compensation for providing administrative services in Texas during the preceding year from complying with the requirements of new §7.1609(c) for that year. Adopted new §7.1609(d)(2) requires an administrator qualifying for the exemption in §7.1609(d)(1) to file a financial statement with the Department that: (i) includes a completed Form Number FIN 490, Certification of Financial Statement, as referenced in

§7.1609(b)(1)(D); and (ii) is verified by at least two officers or other comparable responsible persons of the administrator. Adopted new §7.1609(d)(3) clarifies that an administrator qualifying for the exemption in new §7.1609(d)(1) must still meet the other requirements of new §7.1609. Adopted new §7.1609(e) provides that the Commissioner may request additional information as necessary to determine if an administrator is operating or conducting business in a hazardous or injurious manner.

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

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

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

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

§7.1612. Fiduciary Bank Accounts. Pursuant to the Insurance Code §4151.106(b), adopted new §7.1612(a) requires an administrator to hold all premium in a fiduciary capacity. Adopted new §7.1612(b) requires an administrator collecting or receiving any premium to comply with the Insurance Code §§4151.105, 4151.106, 4151.107, and 4151.108 and adopted new §7.1612. New §7.1612(b) also requires each administrator who receives any premium on behalf of an insurer, HMO, plan sponsor, or group to report the receipt of that premium to the insurer, HMO, plan sponsor, or group within a reasonable amount of time. Adopted new §7.1612(c) requires an administrator to establish at least one fiduciary bank account to hold any

premium collected or received pursuant to new §7.1612. Adopted new §7.1612(d) requires a fiduciary bank account required by adopted new §7.1612(c) to be established and styled as an escrow account. Adopted new §7.1612(e) requires an administrator to maintain each fiduciary bank account at a financial institution that is: (i) organized under the laws of the United States or any state thereof; and (ii) regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies. Additionally, new §7.1612(e) specifies that a fiduciary bank account may only consist of one or more of the following types of investments: (i) cash and cash equivalents, including savings accounts, checking accounts, money market accounts, and certificates of deposit; (ii) non-assessable money market mutual funds that are primarily invested in United States government securities; and (iii) other investments of substantially similar quality, as approved by the Commissioner. Adopted new §7.1612(f) requires an administrator to maintain detailed accounting records for each fiduciary bank account that separately record each deposit and withdrawal from the account. The accounting records must identify each insurer, HMO, plan sponsor, or group for whom the account is maintained. Adopted new §7.1612(g) requires that, upon the reasonable request of the insurer, HMO, plan sponsor, or group, an administrator must provide an insurer, HMO, plan sponsor, or group a copy of all records relating to the requesting entity's account activity in a fiduciary bank account established or maintained by the administrator on behalf of the insurer, HMO, plan sponsor, or group. Adopted new §7.1612(h) provides that all records maintained by an administrator relating to any premium shall be subject to examination by the Commissioner upon request. Pursuant to the Insurance Code §4151.109, adopted new §7.1612(i) prohibits

an administrator from paying a claim from a fiduciary bank account. Finally, adopted new §7.1612(j) provides that new §7.1612 does not authorize any transaction that is otherwise prohibited by law.

§7.1613. Written Agreements Between Administrators and Insurers. Adopted new §7.1613(a) prohibits an administrator from providing administrative services in Texas on behalf of an insurer unless the administrator has entered into a written agreement with the insurer that meets the requirements of the Insurance Code Chapter 4151 and adopted new §7.1613. Adopted new §7.1613(b) permits an administrator subcontractor to meet the requirements of new §7.1613 by entering into a written agreement with the administrator contractor only. Section 7.1613(b) also requires that the written agreement meet the requirements of the Insurance Code Chapter 4151 and new §7.1613, as applicable. Adopted new §7.1613(c) prohibits a written agreement entered into under new §7.1613 from being construed to limit, in any way, an insurer's ultimate accountability and responsibility for compliance with all statutory and regulatory requirements under the Insurance Code, the Labor Code, and rules adopted thereunder. Adopted new §7.1613(d) specifies the requirements for a written agreement entered into under new §7.1613. to include: (i) a requirement that an administrator comply with all statutory, contractual, and regulatory requirements related to a function assumed or carried out by the administrator and related to a plan for which the administrator performs or offers to perform administrative services; (ii) a description of the administrative services the administrator is expected to provide and any applicable instructions related to the performance of those services, including references to an insurer's claims handling practices or procedures; (iii) a provision

relating to the continuity of services and addressing the obligations of the administrator and the insurer under adopted new §7.1615 (relating to Transfer of Books and Records), including the method and manner in which the insurer and administrator will meet those requirements; and (iv) a provision addressing an insurer's obligation to review and audit the performance of its administrators under adopted new §7.1611 (relating to Operational Review and On-Site Audit), including the method and manner in which the insurer will meet those requirements. Adopted new §7.1613(e) also requires a written agreement entered into under new §7.1613 to ensure that the books and records of the insurer remain the property of the insurer at all times and that the books and records of the insurer are available to the insurer or its designee at any time while in the custody of the administrator. Adopted new §7.1613(f), however, permits an administrator to retain a proprietary interest in the books and records of an insurer pursuant to the Insurance Code §4151.113(c) under one condition. Retention of a proprietary interest requires that the written agreement between the administrator and the insurer must specifically identify the items that will be subject to the administrator's proprietary interest. Further, new §7.1613(f) prohibits an administrator from withholding, based upon a claim of proprietary interest, any portion of an insurer's books and records that would restrict the ability of the insurer to comply with statutory, regulatory, or contractual obligations. Adopted new §7.1613(g) permits a master services agreement to be used to meet the §7.1613 requirements. Adopted new §7.1613(h) permits any §7.1613 requirement that does not apply to an administrative service offered or performed by the administrator on behalf of the insurer to be omitted from the written agreement between the administrator and the insurer. New §7.1613(h) also requires

the remainder of the written agreement between the administrator and the insurer to comply with the Insurance Code Chapter 4151 and new §7.1613. Finally, adopted new §7.1613(i) requires a written agreement to meet the requirements of new §7.1613 no later than September 1, 2009.

§7.1614. Prohibited Acts. Adopted new §7.1614(a) prohibits an administrator from: (i) misrepresenting the terms or nature of an agreement with an insurer, HMO, plan sponsor, or group; (ii) making false, misleading, or incomplete comparisons to the agreements of other administrators or persons in order to induce any person to enter into, continue, or discontinue an agreement; (iii) accepting or rejecting risk, other than under the authority of, and in accordance with, a written agreement with an insurer, HMO, plan sponsor, or group; (iv) publishing or circulating any advertising or informational material, benefit descriptions, certificates, booklets, or brochures pertaining to business underwritten by an insurer, HMO, plan sponsor, or group without advance written approval of the insurer, HMO, plan sponsor, or group; (v) pursuant to the Labor Code §415.0036, offering to pay, paying, soliciting, or receiving an improper inducement relating to the delivery of benefits to an injured employee, if the administrator performs administrative services on behalf of a person who is a participant in the workers' compensation system of this state; and (vi) pursuant to the Labor Code §415.0036, improperly attempting to influence the delivery of benefits to an injured employee, including through the making of improper threats, if the administrator performs administrative services on behalf of a person who is a participant in the workers' compensation system of this state. Adopted new §7.1614(b) provides that an

administrator may be subject to other prohibitions under the Insurance Code, the Labor Code, and rules adopted thereunder that are not specified in adopted new §7.1614(a).

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

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

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

§7.1616(a), as determined by the Commissioner, that relate to the financial condition or business operations or conduct of an applicant or administrator in this state, may also indicate that an applicant or administrator is operating in a hazardous or injurious manner.

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

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

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Dual Regulation, Duplicative Requirements, and Inconsistency with Legislative Intent

Comment: One commenter objects to the proposed rules because they may result in dual regulation for individuals and entities or subject them to regulation that creates an

unreasonable burden that is inconsistent with the legislative intent of HB 472. A second commenter requests that the Department remove all unnecessary duplication of existing statutory or regulatory requirements under the Insurance Code or the Labor Code for administrators. Another commenter contends that without a definition of “administrator” that clarifies what it means to “adjust” or settle” a claim, the range of “persons” that will be required under these rules to obtain a certificate of authority is extremely broad and requests clarification on whether independent adjusting firms or other ancillary service providers are “administrators” under Chapter 4151. According to the first commenter, the intent of the Texas Legislature when it passed HB 472 was to provide for the regulation of administrators who are responsible for the day-to-day overall management authority over money and claims. The commenter states that the proposed rules raise questions about the intent of Department staff with regard to the regulation of administrators and other entities or individuals who provide specific services to either an insurance company or the insurer’s administrator and do not adjust or settle claims. The commenter states that the rules should not treat or classify entities or individuals who provide specific services to a self-insured group, the self-insured group's third-party administrator, or an insurers’ third-party administrator who does not collect premiums or contributions from a self-insurance group or adjust or settle claims as an administrator for the purposes of the Insurance Code Chapter 4151. The commenter recommends that the Department clarify the rules to provide that the certificate of authority requirement is limited to an entity that actually adjusts or settles claims. This commenter further objects to the proposed rules because the commenter contends that they may subject persons or entities to dual regulation and dual reporting requirements

not contemplated by the Texas Legislature that would result in an unfair, unreasonable, and overly burdensome regulatory scheme that is not appropriate to implement Chapter 4151 of the Insurance Code. Before inquiring about 19 individuals and entities that the commenter believes should not be subject to the administrator requirements in Chapter 4151 of the Insurance Code and these rules, the commenter reiterates the provisions of §4151.002 of the Insurance Code that exempts certain individuals and entities from regulation as administrators: (i) a person who provides technical, advisory, utilization review, precertification, or consulting services to an insurer, plan, or plan sponsor but does not make any management or discretionary decisions on behalf of the insurer, plan, or plan sponsor; and (ii) a person who adjusts or settles claims in the normal course of the person's practice or employment as a licensed attorney and who does not collect any premium or charge in connection with annuities or workers' compensation benefits. This commenter then lists examples of 19 individuals or entities that contract with, or whose services are used by, self-insurance groups, insurers, and third party administrators. These 19 individuals and entities are (1) attorneys and law firms who provide legal advice and representation in the dispute resolution proceedings managed and conducted by the Division of Workers' Compensation (DWC) and for issues related with the DWC's and the Department's enforcement process; (2) utilization review agents (URA) that handle both prospective and retrospective utilization review, the URA is certified by the Department pursuant to the workers' compensation utilization review rules, Rules 19.2001 – 19.2021; (3) utilization review agents that review medical bills that must be paid by the self-insurance group or a third-party administrator (TPA); the self-insurance group's TPA and TPAs for insurers that have the ultimate decision-

making authority as to whether or not to pay medical bills; (4) case management companies and/or individual case managers that provide consultative and technical services that includes assisting with the case management of different aspects of a claim, e.g. return-to-work, coordination of work status assessment, coordination of appropriate treatment for an injured employee, job site analysis, ergonomic assessments, occupational case management, assessment of maximum medical improvement status, vocational rehabilitation, and management of catastrophic injury cases; (5) actuarial firms that provide consultative services that includes providing statements of actuarial opinion, account audit support, rate-making actuarial services, underwriting audit services, and other actuarial services; (6) EDI trading partner/agents who provide electronic data interchange technical services, software and/or submit claims payment and medical bill payment data to the DWC; (7) safety consultants who provide consultation to self-insured groups (SIG), SIG TPAs and TPAs of insurers for the purpose of improving workplace safety and loss control; (8) peer review doctors who provide prospective, concurrent, and retrospective utilization review services for the purpose of ascertaining the appropriateness of future, on-going, or past healthcare and to address other medical issues related to a specific claim; (9) eBill agents who provide technical services to self-insurance groups for the payment of medical bills electronically transmitted for payment under the provisions of DWC rules – 28 TAC §133.500 and §133.50; (10) certified workers' compensation health care networks contracted with by self-insurance groups as provided for by Chapter 1305 of the Texas Insurance Code and the Department's Chapter 10 Certified Workers' Compensation Healthcare Network Rules; (11) DWC-appointed designated doctors requested by the TPA for the purpose

of obtaining a recommendation about an injured employee's medical condition, to resolve a dispute about an injured employee's work-related injury or occupational illness, or to resolve a dispute regarding the work status and/or impairment rating of an injured employee; the designated doctor process is regulated by the DWC's Chapter 126 rules; (12) required medical examiners (doctors) selected by the TPA for the purpose of obtaining an opinion on the appropriateness of the health care received by employees; required medical examiners are regulated by the DWC's Chapter 126 rules; (13) private investigators or private investigation firms to obtain special investigation unit services associated with the investigation of suspected insurance fraud or to obtain surveillance of injured employees who are suspected of having filed fraudulent claims or exaggerated the extent of the injury and disability; (14) independent adjusters who are licensed adjusters not on the staff of an insurance carrier or self-insured and do not adjust or settle a claim but rather investigate accident sites and obtain statements from injured employees, employers, accident witnesses, treating doctors, and perform related services, e.g. attending a DWC benefit review conference, contested case hearing, and submitting medical dispute resolution responses to the Division of Workers Compensation, and so forth as provided for by §4151.002(13) of the Insurance Code; (15) workers' compensation Austin representatives required by §156.1 of the Labor Code who act, by law, as the insurer's or self-insured group's representative to the DWC and agent for receiving notices, decisions, and orders from the DWC; (16) accident reconstruction experts who provide a technical service that assists in the investigation of a claim by an insurer, self-insurance group or a third-party administrator; (17) home modification contractors who provide a technical service to insurers, self-

insurance group or a third-party administrator and complete modification construction projects that allows disabled injured employees to have better access to their workplaces, work stations, and homes; (18) medical set aside vendors who provide a technical service that provides for Medicare set-aside for the workers' compensation insurers, self-insurance groups, and third-party administrators; and (19) independent claims auditing firms that provide technical and consultative services to insurers, self-insured groups, and third-party administrators and audit their respective claims for compliance and accuracy of payment of claims. According to the commenter, (i) none of these 19 individuals and entities collects premiums or contributions or adjusts or settles claims on behalf of a self-insurance group or insurer; (ii) each of these individuals and entities provides services to a self-insurance group and/or a TPA that are advisory or technical in nature and do not constitute the adjusting or settling of a claim; (iii) when contracting with one of these 19 persons or entities, the self-insurance group, a SIG's TPA, insurer and a TPA retains the decision-making authority for resolving disputed claims issues in benefit disputes, determining whether or not a medical bill is to be paid or denied, determining whether or not health care presented for pre-authorization is approved pursuant to the provisions of DWC Rule 134.600; (iv) the Texas Labor Code and associated rules adopted by the Commissioner of Workers' Compensation regulate these activities and provide for enforcement of the associated rules; (v) the insurer or self-insured group is responsible for any violation of DWC rules as they relate to payment of benefits; and (vi) legislative offices have routinely reinforced this concept when weighing in on rules proposed by the DWC. The commenter further contends that the language in proposed §7.1601(c) appears to

indicate that the Department expects certified workers' compensation health care networks to have to obtain a certificate of authority in addition to that already granted by the Department under the Chapter 10 Certified Workers' Compensation Healthcare Network Rules. According to the commenter, the Commissioner does not have the statutory authority to adopt rules that would result in the dual regulation of these persons. The commenter further asserts that HB 472 requires the rules adopted by the Commissioner to be fair, reasonable, and appropriate to augment and implement the Insurance Code §4151.006. The commenter recommends that the Department: (i) clarify proposed §7.1601(a) and (c) to provide that certified workers' compensation health care networks will not be required to obtain certificates of authority under the Insurance Code §4151 and §§7.1601 – 7.1618 and will not be subject to dual data reporting requirements since they are already required to obtain certificates to operate as workers' compensation health care networks under the Insurance Code Chapter 1305 and the Department's Chapter 10 rules concerning workers' compensation health care networks; (ii) clarify proposed §7.1601(a) to recognize the provisions of the Insurance Code §4151.002 and the fact that §4151.002 identifies specific individuals and entities that are exempted from the provisions of the Insurance Code Chapter 4151 as it applies to the regulation of administrators; (iii) conduct a Department review of the current data reporting requirements of certified workers' compensation networks to ascertain the data currently submitted by certified workers' compensation networks pursuant to the provisions of the Department's Chapter 10 rules; (iv) clarify in the rule adoption preamble that a certified workers' compensation network would only have to obtain a certificate of authority under the Insurance Code §4151.001(1) should they

contract with an insurer or self-insured to perform the duties of an administrator; (v) revise the rules to specifically exempt the 19 entities or individuals listed by the commenter from the administrator certificate of authority requirement as provided in the Insurance Code §4151.002; and (vi) revise the proposed rules in a manner that would not extend the regulatory scheme and the requirement to obtain an administrator certificate of authority to those individuals or entities that do not perform duties of a third-party administrator. The second commenter, in objecting to the duplicative statutory and regulatory requirements, asserts that this examination of existing requirements could reduce costs and eliminate administrative burdens that could ultimately result in savings to policyholders. The commenter further states that while it understands that the Department has made explicitly clear in the rule proposal that duplicative registration and licensing requirements may apply (e.g., proposed new §7.1601(a) and page 4 of 158 in the preamble section), the commenter respectively submits that this duplication is moving in the wrong direction. According to the third commenter, reasonable people may disagree on the merits of the arguments about whether so-called "independent adjusting firms" or other ancillary service providers should be considered "administrators" under Chapter 4151. The commenter states that the rules and Chapter 4151 are not clear on whether the following entities or persons are “administrators” under Chapter 4151: (i) private investigation companies that perform investigations in workers’ compensation claims; (ii) independent adjusters, and the firms they work for, that perform limited assignments on behalf of insurers, such as taking a statement of a witness, claimant, or employer, obtaining medical records from a doctor or hospital, preparing and filing compensability disputes or requests for

designated doctor appointments, etc.; (iii) Austin representatives designated by insurance carriers pursuant to the Labor Code §406.011 and §156.1 of this title that pick up and transmit mail between the DWC and their clients, request record checks and obtain records on prior claims from the DWC, review or propose dispute language to their clients, consult with their clients on whether a claim is compensable, or attend hearings on behalf of clients. The commenter further inquires at what point does the activities of Austin representatives cross the line and become “adjusting” or “settling” claims as those terms are used in the Insurance Code §4151.001.

Agency Response: The Department disagrees with all of the commenter’s recommended changes for the following reasons. The intent of the rules, consistent with the intent of Chapter 4151 as enacted by HB 472, is to regulate administrators in accordance with the Insurance Code Chapter 4151. The Department disagrees that the proposed rules as adopted will subject persons to dual regulation and dual reporting requirements for performing the functions authorized under a single statutory authorization, or result in a regulatory scheme that is unfair, unreasonable, overly burdensome, or inappropriate for implementing the Insurance Code Chapter 4151. This includes the 22 individuals and entities inquired about by two commenters, who, because of the definition of “administrator” in the Insurance Code §4151.001(1) and the statutory exemptions specified in the Insurance Code §4151.002 and §4151.0021, may or may not be subject to the rules and Chapter 4151 of the Insurance Code. The Department further disagrees that the adopted rules require all certified workers’ compensation health care networks to obtain a certificate of authority under the Insurance Code Chapter 4151 to act as an administrator or that the rules as adopted

need to be clarified to specifically exempt from regulation under the Insurance Code Chapter 4151 the individuals or entities listed by the two commenters. First, the Department believes that these rules clearly, fairly, reasonably, and appropriately implement and augment the Insurance Code Chapter 4151. The rules, which are consistent with the regulatory scheme under Chapter 4151, treat or classify entities and individuals who act as or hold themselves out as administrators in accordance with the Insurance Code Chapter 4151. Section 7.1601 specifies who the rules apply to and provides that a person acting as or holding itself out as an administrator must meet the requirements of the Insurance Code Chapter 4151 and this subchapter in addition to any other requirements applicable to that person under the Insurance Code Chapters 1272 or 1305 or the Labor Code Chapters 407 or 407A and any rules adopted thereunder except as otherwise provided by statute or rule. Section 7.1603 provides that any person acting as or holding itself out as an administrator, administrator contractor, or administrator subcontractor must hold a certificate of authority under the Insurance Code Chapter 4151--unless a person meets an exemption under the Insurance Code §§4151.002, 4151.0021, or 4151.004. Sections 7.1601 and 7.1603 are consistent with the provisions of the Insurance Code §4151.051(a), which prohibit “[a]n individual, corporation, organization, trust, partnership, or other legal entity” from acting as or holding itself out as an administrator unless the entity is covered by and is engaging in business under a certificate of authority issued under Chapter 4151. Thus, by its plain language, the Insurance Code §4151.051(a) requires not only persons that act as administrators to obtain certificates of authority but also persons that hold themselves out as administrators. It is clear from this plain language that the intent is

not to regulate as administrators only those persons that actually adjust or settle claims or only those administrators who are responsible for the day-to-day overall management authority over money and claims, but also those persons that hold themselves out as administrators, as contemplated under §4151.051(a). The following scenario is offered for illustrative purposes. The scenario assumes that a person that does not meet any of the exemptions in the Insurance Code Chapter 4151 enters into a contract with an insurer, which delegates to this person the authority to adjust or settle a claim on behalf of the insurer. This person never actually performs the function of adjusting or settling a claim on behalf of the insurer. Under this scenario, the person is holding itself out as an administrator, as contemplated under the Insurance Code §4151.051(a), despite the fact that the person never actually adjusts or settles a claim on behalf of the insurer. None of the Chapter 4151 provisions limit the certificate of authority requirement in §4151.051(a) in the manner requested by one commenter, i.e., that only a person that is responsible for the day-to-day overall management authority over money and claims is required to obtain a certificate of authority. Therefore, these rules cannot provide that only a person that is responsible for the day-to-day overall management authority over money and claims is required to obtain a certificate of authority.

Additionally, §7.1601 and §7.1603 as adopted clearly and appropriately incorporate the definitions of “administrator,” “administrator contractor,” and “administrator subcontractor” in §7.1602(1), (3), and (4) respectively. Sections 7.1602(1), (3), and (4) as adopted, in turn, clearly and appropriately incorporate and are consistent with the statutory definition of the term *administrator* that is in the Insurance Code §4151.001(1) in combination with the other provisions of Chapter 4151, including

the exemptions specified in §4151.002 and §4151.0021. The definitions in §7.1602(1), (3), and (4) explicitly incorporate the definition of administrator in the Insurance Code §4151.001(1) and the exemptions enumerated in §4151.002 and §4151.0021. Section 4151.001(1) defines an *administrator* as a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. Further, §4151.001(1) provides that the term does not include a person described by §4151.002, but provides that the term includes: (i) a delegated entity under the Insurance Code Chapter 1272; and (ii) a workers' compensation health care network authorized under the Insurance Code Chapter 1305 that administers a workers' compensation claim for an insurer, including an insurer that establishes or contracts with the network to provide health care services. Section 7.1602(1) also provides that the term “administrator” includes administrator contractors and administrator subcontractors. This provision is based on the Insurance Code §§4151.001(1), 4151.002, 4151.0021, and 4151.051(a), which provide that regardless of a person’s position in a contractual relationship, whether as a direct contractor or down-stream subcontractor, a person is an administrator for purposes of Chapter 4151 and the rules if that person performs or offers to perform a function as an administrator as defined in §4151.001(1), and that person does not meet an exemption described in §4151.002 or §4151.0021. For clarity, the definitions in §7.1602(3) and (4) for the terms “administrator contractor” and “administrator subcontractor” reiterate these two exemptions. Thus, in order to determine whether a person is an *administrator* as defined in adopted §7.1602(1) or as that term is used in the adopted rules, including

§7.1601 and §7.1603, it is necessary to evaluate the functions or services that the person is performing or providing, or offering to perform or provide and whether the person is specifically exempted from any of the requirements of the Insurance Code Chapter 4151. Whether a particular person qualifies as an “administrator” or meets an exemption under Chapter 4151 and the adopted rules is a case-by-case, fact-specific determination. Therefore, each of the individuals and entities that the two commenters inquired about would be subject to this case-by-case, fact-specific determination to ascertain whether each of these persons qualifies as an “administrator” and is therefore, subject to regulation under Chapter 4151 and these rules. Pursuant to the Labor Code Chapter 407A, the Insurance Code Chapter 4151 and the §7.1601 and §7.1603 rules, if the person qualifies for a specific exemption in the Insurance Code §4151.002 or §4151.0021, the person is not an administrator for the purpose of these rules. However, if the person does not qualify for one of these exemptions, and the person collects or offers to collect premiums or contributions from residents of this state or adjusts, settles, or offers to adjust or settle claims for residents of this state, in connection with annuities or life, health, accident, pharmacy, or workers' compensation benefits, the person meets the definition of *administrator* in the Insurance Code §4151.001(1) and new §7.1602(1). This is true, regardless of whether the person is also performing or providing other functions or services that subject the person to compliance with the Insurance Code and the Labor Code. Thus, if a person is performing any act that is the act of an administrator under Chapter 4151 of the Insurance Code or under these rules or is holding itself out as an administrator under §4151.051(a) and does not meet an exemption in §4151.002 or §4151.0021, the person

is an administrator for purposes of Chapter 4151 and these rules. Section 7.1601(a), which is adopted without change to the proposed text, clarifies that a person acting as or holding itself out as an administrator may be simultaneously subject to the requirements of other provisions of the Insurance Code, the Labor Code, or rules adopted thereunder if the functions or services performed or offered by that person require such regulation. In such event, the person will be required to hold all appropriate authorizations pursuant to the Insurance Code or the Labor Code in order to perform or offer to perform the regulated functions and services. This is because a single authorization issued pursuant to the Insurance Code or the Labor Code does not authorize a person to perform or offer to perform any additional regulated functions or services than those specified by the authorization. Each authorization relates to specific functions or services regulated under specific Insurance Code or Labor Code provisions. Therefore, a person must hold the applicable authorization in order to perform or offer to perform the corresponding regulated functions or services. The following example is provided for illustrative purposes. A person holds a certificate issued by the Department pursuant to the Insurance Code Chapter 1305 to operate a workers' compensation network in this state. The person acts as or holds itself out as an administrator by settling a claim on behalf of the insurer that established or contracted with this certified workers' compensation network to provide health care services. Under §4151.001(1), the term "administrator" includes a workers' compensation health care network authorized under Chapter 1305 that administers a workers' compensation claim for an insurer, including an insurer that establishes or contracts with the network to provide health care services. Therefore, in this example,

the person will be simultaneously subject to the requirements of the Insurance Code Chapters 1305 and 4151 and the implementing rules of both chapters. The person will be required to hold a separate authorization under each of these chapters in order to perform or provide the functions and services of a workers' compensation network and an administrator. This is because the authorization issued to the person under Chapter 1305 to operate as a workers' compensation network in this state only authorizes the specific functions regulated under Chapter 1305. That specific authorization does not authorize the person to perform other activities that are regulated under other Insurance Code or Labor Code provisions. In order for the person to act as an administrator under the Insurance Code Chapter 4151, the person must hold a separate authorization issued pursuant to Chapter 4151. The person will be subject to the requirements of Chapter 1305 and the Chapter 1305 implementing rules for its functions related to operating a workers' compensation health care network. The person will also be simultaneously subject to the requirements of the Insurance Code Chapter 4151 and the Chapter 4151 implementing rules for acting as or holding itself out as an administrator. In order for the person to engage in each of these regulated activities, the person must hold separate authorizations issued under the applicable Insurance Code or Labor Code statutes and must comply with the rules adopted under each of those statutes. Section 7.1601(c) further reinforces this requirement by providing that an administrator must meet the requirements of the Insurance Code Chapter 4151 and these rules in addition to any other requirements that apply to that person as: (i) a delegated entity or a delegated third party administrator of a health maintenance organization (HMO) under the Insurance Code Chapter 1272, (ii) a workers'

compensation healthcare network under the Insurance Code Chapter 1305, (iii) a qualified claims servicing contractor under the Labor Code Chapter 407, or (iv) an administrator or service company under the Labor Code Chapter 407A. Further, adopted new §7.1601 and §7.1603 are consistent with the Insurance Code §1305.008. Section 1305.008 requires a person to hold a certificate of authority issued under Chapter 4151 if that person provides the functions of an administrator under Chapter 4151. Currently, Department records indicate that persons holding certificates of authority issued under the Insurance Code Chapter 1305 to operate as workers' compensation networks also hold certificates of authority issued under Chapter 4151 to act as administrators. However, if a person, including a certified workers' compensation network, does not act or hold itself out as an administrator, it would not need to obtain a certificate of authority under the Insurance Code §4151.051 or otherwise need to meet the requirements of the Insurance Code Chapter 4151 and these rules. Moreover, if a person, including a certified workers' compensation health care network, acts or holds itself out as an administrator, but meets an exemption specified in Chapter 4151, then it would not need to obtain a certificate of authority under the Insurance Code §4151.051 or otherwise need to meet the requirements of the Insurance Code Chapter 4151 and these rules pertaining to administrators. Therefore, these rules, as proposed and adopted, do not result in the dual regulation of any persons or entities unless such persons or entities are performing separate functions which require separate authorizations under the applicable statutes. Accordingly, the issuance of a separate statutory authorization, i.e., a certificate of authority to perform the functions of an administrator as specified in Chapter 4151 of the Insurance Code, in addition to other

statutory authorizations for the performance of other types of functions not regulated under Chapter 4151 is consistent with the purpose and intent of HB 472.

With regard to the comment requesting that the Department remove all unnecessary duplication of existing statutory or regulatory requirements under the Insurance Code or the Labor Code for administrators, the Department does not have the authority to remove duplicative statutory requirements; only the Legislature can do that. The Department does not agree that there are any duplicative regulatory requirements in these rules. This is based on the Department's preceding review of the individual provisions of these rules and the statutes implemented by these rules. The Department disagrees that §7.1601(a) and page 4 of 158 in the proposal preamble, as the commenter contends, state or imply that duplicative registration or licensing requirements may apply. Instead, §7.1601(a) and page 4 of 158 of the proposal clarify that a person acting as or holding itself out as an administrator may be simultaneously subject to the requirements of other provisions of the Insurance Code, the Labor Code, or rules adopted thereunder if the functions or services performed or offered by that person require such regulation. As previously explained in this response, in such event, the person will be required to hold all appropriate authorizations pursuant to the Insurance Code or the Labor Code in order to perform or offer to perform the regulated functions and services authorized under each of the certificates of authority.

Vagueness, Confusion, and Substantive Due Process Concerns

Comment: One commenter contends that the proposed language in the rules is so vague and confusing that an insurer or other regulated person does not know if a

proposed rule applies to them or what is expected of them. The commenter recommends that the rules be clarified to allow men and women of common intelligence to know if a proposed rule applies to them or what is expected of them. The commenter states that the Texas Constitution, Article I, Sections 13 and 19 guarantees due process; the commenter cites to various court opinions for support. The commenter states that individuals must be afforded both substantive and procedural due process. (*Texas Workers' Comp. Comm'n v. Patient Advocates*, 136 S.W.3d 643, 658 (Tex. 2004)). Substantive due process protects against the arbitrary and oppressive exercise of government power, regardless of the fairness of the procedures. *Daniels v. Williams*, 474 U.S. 327, 331, 88 L. Ed. 2d 662, 106 S. Ct. 662 (1986). A statute which forbids or requires the doing of an act in terms so vague that men and women of common intelligence must necessarily guess at its meaning and differ as to it application violates the first essential protection of due process of law. *Baker v. State*, 50 S.W.3d 143, 145 (Tex. App. – Eastland 2001, pet. ref'd) *citing Connally v. General Const. Co.*, 269 U.S. 385, 46 S. Ct. 126, 70 L. Ed. 322 (1926). A statute is void for vagueness if it "fails to give a person of ordinary intelligence fair notice that his contemplated conduct is forbidden by the statute." *Baker v. State*, 50 S.W.3d at 145; *citing Papachristou v. City of Jacksonville*, 405 U.S. 156, 92 S. Ct. 839, 31 L. Ed. 2d 110 (1972).

Agency Response: The Department disagrees with the commenter. The commenter does not specify which of the rules are vague and confusing. Following a thorough review of the proposed rules, the Department has identified and revised two of the proposed rules to (i) clarify in §7.1613(d)(1) one of the requirements that must be included in each written agreement between an insurer and an administrator; and (ii)

clarify in §7.1616(b) the facts and circumstances which may indicate that an applicant or administrator is operating or conducting business in a potentially hazardous or injurious manner to an insured person or the public. These clarifications do not materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice. Section §7.1613(d)(1) as adopted provides that a written agreement entered into under §7.1613 must include a requirement that the administrator comply with all statutory, contractual, and regulatory requirements related to a function assumed or carried out by the administrator and related to a plan for which the administrator performs or offers to perform administrative services. Section §7.1616(b) as adopted provides that other facts and circumstances not specified in §7.1616(a), as determined by the Commissioner, that relate to the financial condition or business operations or conduct of an applicant or administrator in this state may also indicate that an applicant or administrator is operating in a hazardous or injurious manner. The Department is of the opinion that the rules as adopted are not vague and confusing and that a person or entity will be able to determine whether the rules apply to them by a plain reading of the rules. For example, §7.1601(a) states that these rules apply to a person acting as or holding itself out as an administrator in any capacity, regardless of whether the person holds another authorization under the Insurance Code or Labor Code-- unless there is an exception or exemption either in these rules or Chapter 4151 of the Insurance Code that results in the rules not being applicable. Section 7.1602(1) defines “administrator” to be an individual or entity that meets the definition of “administrator” in the Insurance Code §4151.001(1). The §7.1602(1) definition further states that the term includes administrator contractors and

administrator subcontractors but does not include a person described by the Insurance Code §4151.002 or §4151.0021. Therefore, a person who is trying to determine whether they are required to comply with the rules must read, in addition to the definition of “administrator” in §7.1602(1), the statutory definition of “administrator” in the Insurance Code §4151.001(1) and the definitions of the terms “administrator contractor” and “administrator subcontractor” in §7.1602(3) and (4). The person must also read §4151.002 or §4151.0021 of the Insurance Code to determine if they meet one of the exemptions. In addition, the person must read the entirety of the rules to determine any exemptions or exceptions to the rule requirements. For example, under §7.1603(a), relating to certificate of authority requirements, a person acting as or holding itself out as an administrator is not required to hold a certificate of authority under the Insurance Code Chapter 4151 if the person meets the exemption under the §4151.004. Also, under §7.1605(a), relating to notification requirements, an insurer or HMO that is acting as or holding itself out as an administrator and that is not exempt under the Insurance Code §4151.002(3) or (4) is subject to all provisions of the rules, except §7.1603, §7.1604, and §7.1609(c) and (d)(1) and (2) (relating to required certificate of authority, certificate of authority application, and annual report). Under §7.1609(d), relating to annual report requirements, an administrator who receives less than $10 million in compensation for providing administrative services in Texas during the preceding calendar year is exempt from the audit report requirements in §7.1609(c). Also, under §7.1611(g), relating to operational review and on-site audit requirements, an insurer may meet the §7.1611 requirements for an administrator subcontractor by reviewing and auditing the administrator contractor only, provided that: (i) the information

supplied to the insurer by the administrator contractor includes all necessary and relevant information relating to the administrator subcontractor; and (2) no evidence of material non-compliance by the administrator subcontractor exists. Additionally, §7.1613(b), relating to written agreements between administrators and insurers, provides that an administrator subcontractor may meet the contracting requirements of §7.1613 by entering into a written agreement with an administrator contractor, provided that the written agreement meets the requirements of the Insurance Code Chapter 4151 and §7.1613. The structure of these rules, which references statutory provisions in order to complement many of the rule provisions, is standard rule structure for the Department. Therefore, in order to fully understand and comply with many of the rules, it is necessary to read the rules in conjunction with the statute. This is commonly found in Department rules as well as in other state agency rules. The Department does not agree that this structure results in a rule that is so vague and confusing that it cannot be understood by persons of ordinary intelligence. These rules are necessary to implement the provisions of Chapter 4151. Therefore, the rules either reference applicable provisions of Chapter 4151 (and therefore must be read in conjunction with these sections) or simply specify the requirements necessary to implement the provisions of Chapter 4151. The following are several examples: (i) §4151.002 and §4151.0021, relating to exemptions, are addressed in §7.1601(e) and §7.1602(1), (3) and (4); (ii) §§4151.006, 4151.101, 4151.102, 4151.103(a), 4151.1042(a), 4151.110, and 4151.257, relating to written agreements, are addressed in §7.1613; (iii) §4151.051, relating to certificate of authority requirements, is addressed in §7.1603; (iv) §4151.052(b), relating to Department notification requirements, is addressed in §7.1606

and §7.1607; (v) §4151.1042, relating to review and on-site audit requirements, is addressed in §7.1611; (vi) §§4151.106 - 4151.108, relating to fiduciary duty and account requirements, are addressed in §7.1612; (vii) §4151.205, relating to annual reporting requirements, is addressed in §7.1609; and (viii) §4151.301(8), relating to hazardous or injurious operating conditions, is addressed in §7.1609(e) and §7.1616.

The Department understands that HB 472, which brings all workers' compensation administrators into the regulatory framework of Chapter 4151 and under the regulatory purview of the Department, enacts a significant change that may be difficult for those persons who have not been previously regulated by the Department. As a result, the Department has endeavored to develop rules that are as simplified, and therefore as understandable, as possible, for those persons who are new to such regulation.

Regulation of Law Firms and/or Individual Attorneys as Administrators

Comment: One commenter objects to the regulation of individual attorneys and/or law firms as administrators under the proposed rules. A second commenter requests clarification in the rules as to whether and to what extent an individual attorney or a law firm can be regulated as an "administrator" under the proposed rules or the Insurance Code Chapter 4151. The first commenter raises several constitutional and separation of powers issues and a legislative intent argument to support the position that an attorney or law firm cannot be regulated as a third-party administrator under Chapter 4151 of the Insurance Code. The commenter's constitutional objections include: (i) any attempt to include law firms in the group of organizations requiring licensure under

Chapter 4151 carries separation of powers concerns and would be unconstitutional under the Texas Constitution, Section I, Article II; (ii) there is a 1999 Texas Supreme Court case to support the principle that regulation of attorneys and the firms in which they organize is the responsibility of the Supreme Court of Texas and the State Bar of Texas; (iii) because the regulation of the practice of law by attorneys and the law firms they work for is the responsibility of the Supreme Court of Texas and the State Bar of Texas, any attempt by the Department to impose a licensure obligation on law firms would impinge upon the authority of the Texas Supreme Court and the State Bar of Texas to regulate the practice of law; and (iv) because the authority to license attorneys (and the law firms by which many of them are organized) rests with the Supreme Court of Texas, and because such authority is grounded in the Texas Constitution, it is doubtful whether an express legislative grant of licensure authority to an administrative agency with regard to licensure of law firms would be constitutional. The commenter's objections also include: (i) a common thread running throughout the Insurance Code Chapter 4151 is the Legislature's attempt to enlarge the Department's regulatory authority without impinging upon other regulatory schemes; the structure of the Insurance Code and the background and purpose of HB 472, as described in the bill analysis, make it apparent that the intent of the Legislature in HB 472 is to include workers' compensation administrators within the regulatory purview of the Department so long as the administrators were otherwise administratively unregulated; (ii) the statute provides an exemption for licensed adjusters, but offers no similar exemption for adjusting companies and at first glance, there appears to be parallel regulatory intent with regard to attorneys, but on closer examination, it should be evident that the

Legislature never intended to include individual attorneys or law firms in that group of organizations requiring licensure under Chapter 4151; (iii) semi-annual audits and on-site examinations by the Commissioner would be administratively difficult, if not impossible, to implement and might run afoul of the attorney-client privilege; (iv) a law firm is not a third-party administrator; (v) attorneys do not adjust claims; they provide legal representation to self-insurance groups, insurers, and third-party administrators; and (vi) the Legislature has not expressly delegated licensure authority to the Department, and therefore, the Department does not have legislative or other authority to designate and regulate attorneys and law firms as third-party administrators. According to the second commenter, the statute contains an express exemption for licensed attorneys, but not for law firms comprised of licensed attorneys. This commenter asserts that clearly an individual attorney that adjusts or settles workers' compensation claims is not considered an "administrator" under the Insurance Code §4151.002(12). This commenter states that arguably under the statute, law firms who "adjust or settle" workers' compensation claims are required to obtain a certificate of authority as an "administrator," just as independent adjusting firms must do. This commenter states that the Insurance Code Chapter 4151 and the proposed rules do nothing to clarify the question of whether law firms should be considered as administrators.

Agency Response: The Department agrees that regulating the practice of law by individual attorneys and law firms is the responsibility of the Supreme Court of Texas and the State Bar of Texas. The Department also agrees that the Department does not have legislative or other authority to regulate individual attorneys and law firms to the

extent that they are engaging in the practice of law. Therefore, the Department has not historically attempted to apply Chapter 4151 or the existing administrator rules to individual attorneys or law firms practicing law; no change in this practice is intended by these rules, either as proposed or adopted. Section 4151.001(1) defines “administrator” in pertinent part to mean “a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. . . . The term does not include a person described by Section 4151.002.” Section 4151.002(12) provides that a person is not an administrator if the person is “a person who adjusts or settles claims in the normal course of the person's practice or employment as a licensed attorney and who does not collect any premium or charge in connection with annuities or with life, health, accident, pharmacy, or workers' compensation benefits. (emphasis added) Therefore, under §4151.001(1) and §4151.002(12), if an individual attorney adjusts or settles claims in the course of his/her practice and collects any premium or charge in connection with annuities or with life, health, accident, pharmacy, or workers’ compensation benefits, the individual attorney is not eligible for the exemption under the Insurance Code §4151.002(12).

Law firms are clearly not required to obtain a certificate of authority as an "administrator" under the Insurance Code Chapter 4151 to engage in the practice of law. As previously stated, §4151.001(1) defines “administrator” in pertinent part to mean “a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. . . .

The term does not include a person described by Section 4151.002." Section 4151.051(a) provides that "an individual, corporation, organization, trust, partnership, or other legal entity may not act as or hold itself out as an administrator unless the entity is covered by and is engaging in business under a certificate of authority issued under" Chapter 4151 of the Insurance Code. Therefore, under the provisions of §4151.001(1) and §4151.051(a), any law firm whose activities go beyond the practice of law by virtue of acting as or holding itself out as an administrator as defined in the Insurance Code §4151.001(1), must hold an administrator certificate of authority and comply with the requirements in these rules and Chapter 4151, unless otherwise exempt under the Insurance Code or Labor Code.

Exemption for Pharmacy Benefit Managers

Comment: One commenter states an exemption for a pharmacy benefit manager (PBM) may exist under the Insurance Code §4151.002(14) because most, if not all, PBMs perform some kind of clinical review (either in house or contract) and some have clinical pharmacists on board to coordinate this type of service. According to the commenter, (i) PBMs provide technical, advisory, and consulting services as well, but do not make any decisions on behalf of the insurer or third party administrator; (ii) a PBM could be defined as a processing agent under the Insurance Code §4151.0021 and the Labor Code §413.0111; and (iii) PBMs do not collect premiums or contributions, nor do they adjust or settle any claims in the state of Texas (or any state).

Agency Response: While the Department agrees that certain PBMs may meet the exemption under the Insurance Code §4151.002(14) or the exemption under the

Insurance Code §4151.0021 for certain workers' compensation processing agents, the Department does not agree that all PBMs will meet one of these exemptions. PBMs may perform a variety of functions that at times may include (i) contracting with a network of pharmacies; (ii) establishing payment levels for provider pharmacies; (iii) negotiating rebate arrangements; (iv) developing and managing formularies, preferred drug lists, and prior authorization programs; (v) maintaining patient compliance programs; (vi) performing drug utilization review; and (vii) operating disease management programs and mail order services. The Insurance Code §4151.151 specifically provides that the term "pharmacy benefit manager" means a person, other than a pharmacy or pharmacist, who acts as an administrator in connection with pharmacy benefits. Therefore, a person that meets the definition of a "pharmacy benefit manager" in the Insurance Code §4151.151 is considered an "administrator" for purposes of Chapter 4151 and these rules and is subject to regulation under Chapter 4151 and these rules. This includes the requirement to obtain a certificate of authority to act as administrator under the Insurance Code Chapter 4151. Currently, approximately 30 entities describing themselves as PBMs or as providing PBM functions hold administrator's certificates of authority issued by the Department under Chapter 4151.

Whether any person, including a PBM is an "administrator," as defined in the Insurance Code §4151.001(1) and §7.1602(1), or meets an exemption described in §4151.002 or §4151.0021 is based entirely on the particular facts and circumstances and the various functions or services being performed or offered to be performed by the PBM. The Department determines whether a PBM is an "administrator" as defined in

the Insurance Code §4151.001(1) and §7.1602(1) or meets an exemption under §4151.002 or §4151.0021 in the same manner that it makes this determination for any other person. The determination is based upon a case-by-case analysis of the particular facts and circumstances, including the contractual and employment relationship and the actual services and functions being performed or offered to be performed. To the extent any person, including a PBM, collects premiums or contributions, or adjusts or settles claims, or offers to provide these administrative services, for residents of this state in connection with annuities or life, health, accident, pharmacy, or workers' compensation benefits and does not meet an exemption under the Insurance Code §4151.002 or §4151.0021, the person is an administrator under Chapter 4151 and these rules. As such, the person is subject to the requirements in Chapter 4151 and these rules, including the requirement to obtain a certificate of authority from the Department to act as an administrator under the Insurance Code Chapter 4151. This is true regardless of whether the person, including a PBM, is also performing or offering to perform functions or services in addition to collecting premiums or contributions or adjusting or settling claims.

Requested Definitions for the Terms "adjust" and "settle"

Comment: Three commenters recommend that the proposed rules define the terms "adjust," "adjusts," "adjusting," and/or "settle." One of these commenters specifically recommends including in the rules a definition of the terms "adjusts" and "adjusting" to state "the investigation, management, supervision of the handling of or settling of losses on behalf of an insurer, administrator, plan, plan administrator or plan sponsor." This

commenter states that the rules need to clarify the terms “adjusting” and ”adjust” in order to restrict the scope of the rules to individuals and entities that actually collect premiums or adjust or settle claims and to exclude “down stream” contractors (vendors) of insurers and sub-contractors (vendors) of third-party administrators that do not have the ultimate decision-making authority when handling aspects of insurance claims, e.g., legal representation, utilization review, peer review, case management of workers’ compensation medical benefits, etc. The other two commenters note that neither the Insurance Code 4151 nor the proposed rules define the terms “adjust” or “settle” or “adjusts” or “settles.” One of these commenters states that the terms “adjust” or “settle” are key to understanding the intended scope of the rule. The other commenter states that adjusters are frequently asked to performed limited assignments on behalf of insurers. The commenter contends that if their activities can be considered to be “adjusting” or settling,” then the commenter assumes that these persons must be licensed as “administrators,” but that the rules are not clear on that point.

Agency Response: The Department does not agree that it is necessary to define these terms and believes that to do so could result in unnecessary ambiguity. The rules in §§7.1601 - 7.1605, 7.1607, 7.1609, 7.1611, and 7.1613 – 7.1617 clearly and appropriately incorporate the terms “adjusting” and “settling” as used in the Insurance Code Chapter 4151, including in the definition of the term “administrator” in §4151.001(1). The Insurance Code Chapters 4101 and 4102 regulate adjusters and adjusting and prescribe the requirements applicable to obtaining an adjuster's license. The Department declines to adopt a more narrow definition of "adjusting,” “adjust,” “adjusts,” or “settle” than may be contemplated by these chapters. Any definition of

these terms in these adopted rules may have an unanticipated effect upon the application of the term “adjust,” “adjusts,” “settles,” or "adjuster" in these chapters or in the interpretation of the term "claims adjuster" in other Code provisions or Department rules. The Department has had experience applying the statutory terms in the Insurance Code Chapter 4151 prior to the enactment of HB 472 in the context of life, health and annuities business, and has encountered no problems applying them. Department experience demonstrates that whether or not an activity falls within the meaning of the statutory terms “adjusts” or “settles” claims necessitates a fact-specific, case-by-case determination. Therefore, the Department disagrees that the rules must define these terms in order to determine the proper scope of the applicability of the rules.

Requested Definitions for the Terms “discretionary decision” and “management decision”

Comment: One commenter requests that the terms “management decision” and “discretionary decision” be defined in the rules to provide that the decisions must be final, ultimate decisions on an aspect of how the claim is to be handled and adjusted. The commenter further recommends that the definitions provide that administrator contractors and vendors who do not make final, ultimate decisions or are limited by contract or a master services agreement shall be deemed as not possessing the authority to make management and discretionary decisions for the purpose of the application of the rules. Another commenter states that it is a “fine point” whether certain activities described in its comment involve "management or discretionary

decisions" on behalf of the insurer and that the rules do not provide effective guidance. The commenter questions how may one act as a utilization review agent, or handle precertification requests, or audit medical bills, or assist carriers by setting up independent medical examinations or peer reviews without making any discretionary decisions as implied by the Insurance Code §4151.002(14). The commenter further states that it is unclear if certain activities of private investigation companies involve “discretionary decisions” and therefore, would not be exempted under the Insurance Code §4151.002(14). This includes private investigation companies who are hired to perform investigations in workers' compensation claims, such as taking statements, and who sometimes are given authority to make discretionary decisions for carriers and third-party administrators. Additionally, the commenter contends that arguably the following activities involve “discretionary decisions” and thus would not be exempted under the Insurance Code §4151.002(14): (i) attendance by a carrier’s “representative” (a term which includes attorneys and adjusters) at a benefit review conference on behalf of a carrier; (ii) independent adjusters who perform investigations, which may involve discretionary decision-making; and (iii) adjusters who propose language to resolve disputed issues concerning workers’ compensation benefits or who decide whether to file a dispute on behalf of a carrier.

Agency Response: The Department does not believe that it is necessary to define the terms “discretionary decision” or “management decision” and that to do so could result in unnecessary ambiguity or have an unanticipated effect upon the application of the term "administrator" in Chapter 4151 or the adopted rules. The Insurance Code Chapter 4151 uses the terms “management or discretionary decisions” in the exemption

to the term “administrator” enumerated in §4151.002(14). Any person determined to make any management or discretionary decisions on behalf of an insurer, HMO, group, plan, or plan sponsor regarding the settlement or adjustment of claims for or collection of premiums or contributions from residents of this state in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers’ compensation benefits does not meet the exemption in §4151.002(14), and is an administrator for purposes of regulation under Chapter 4151 and these rules--unless the person meets another exemption in §4151.002 or the exemption in §4151.0021. Under the Insurance Code §4151.001(1) and §4151.051(a) and §§7.1601, 7.1602(1), and 7.1603, for a person to be considered an administrator under Chapter 4151 and the rules, the person first has to perform or offer to perform the adjustment or settlement of claims for or collection of premiums or contributions from residents in this state in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers’ compensation benefits. If a person is performing or offering to perform one of more of these administration functions, the Department then determines if the person meets a statutory exemption, including but not limited to the exemption provided in the Insurance Code §4151.002(14). Section 4151.002(14) provides that a person is not an administrator if the person “provides technical, advisory, utilization review, precertification, or consulting services to an insurer, plan, or plan sponsor but does not make any management or discretionary decisions on behalf of an insurer, plan, or plan sponsor.” Whether any person, including those persons mentioned by one of the commenters, is delegated management or discretionary authority or makes management or discretionary decisions regarding the settlement or adjustment of

claims for or collection of premiums or contributions on behalf of an insurer, plan, or plan sponsor is determined on a case-by-case, fact-specific basis. For example, one element of consideration in the Department's determination of whether a person is an administrator is the identity of the party that is responsible for the day-to-day management of the premium collection, claim payment, and/or adjustment functions and which party has final decision-making authority for the payment of claims. Also, a second element is whether there are any limitations in written agreements that prohibit a person from making a discretionary decision or management decision. Another important element is the actual services or functions being performed or offered to be performed by the person, rather than the title or name used to describe the person. The Department has applied the exemption in the Insurance Code §4151.002(14) on a case-by-case, fact-specific basis to regulatory situations related to annuities, or life, health, accident benefits since at least September 1, 1989, when Chapter 4151 (formerly Article 21.07-6) was first enacted. It is the Department's experience that this application has not resulted in undue burdens on the insurance industry or individuals or entities or in implementation or compliance difficulties. Under these rules, the Department will continue the practice of determining the applicability of exemptions listed in §4151.002 and §4151.0021 on a case-by-case, fact-specific basis, applying the ordinary meaning of the words used in the exemptions.

The Department disagrees with the commenter recommending that the rules provide that administrator contractors and vendors who do not make final, ultimate decisions or are limited by contract or a master services agreement shall be deemed as not possessing the authority to make management and discretionary decisions for the

purpose of the application of the rules. Section §4151.002(14) does not contain such limitations, and the Department does not have the authority to limit §4151.002(14) in accordance with the commenter's suggestion.

With regard to workers' compensation benefits, the Department is aware that many parties are involved in processing these types of benefits and anticipates that the Department's fact-specific determination will reflect that a relatively large number of these persons meet the statutory exemption in §4151.002(14). Nevertheless, the Department also believes that it is possible that certain persons who act as utilization review agents, handle precertification requests, audit medical bills, perform investigations, or assists carriers by setting up independent medical examinations or peer reviews may also perform the functions of an administrator under Chapter 4151 by making management or discretionary decisions on behalf of the insurer, plan, or plan sponsor, while engaged in the process of adjusting or settling claims, collecting premiums or contributions, or offering to perform these functions or services.

The Department agrees that independent adjusters who perform investigations and who make discretionary decisions and adjusters who propose language to resolve disputed issues concerning workers' compensation benefits or who decide whether to file a dispute on behalf of a carrier are not exempt under §4151.002(14). However, §4151.002(13) contains an exemption from Chapter 4151 regulation for individual adjusters "engaged in the performance of an individual's powers and duties as an adjuster in the scope of the individual's license." Moreover, §4101.001 of the Insurance Code defines an adjuster as an individual whose functions include, but are not limited to, investigating, adjusting and supervising the handling of workers' compensation

claims, including performing these functions on behalf of an administrator. Thus, although the Department's fact-specific determination may yield a different result, the Department anticipates that many individual adjusters will be exempt from Chapter 4151 regulation under §4151.002(13). Those individual adjusters that function within the scope of their license as an adjuster are not subject to the certificate of authority and other requirements of Chapter 4151.

Interpretation of the Insurance Code §4151.0051, relating to Referral to Adjuster by Administrator

Comment: One commenter inquires whether, under the Insurance Code §4151.0051, an administrator may refer a claim or loss for adjustment in this state to not only an individual purporting to be acting as an adjuster as long as that individual holds an adjuster license under the Insurance Code Chapter 4101, but also to independent adjusting firms that do not hold certificates of authority as administrators under the Insurance Code Chapter 4151. The commenter states that neither the statute nor the proposed rules make this clear.

Agency Response: Section 4151.0051 does not authorize or permit an administrator to refer a claim or loss for adjustment to an independent adjusting firm that does not hold a certificate of authority under the Insurance Code Chapter 4151. Instead, §4151.0051(a) prohibits an administrator from knowingly referring a claim or loss for adjustment in this state to an individual purporting to be or acting as an adjuster unless

the individual holds a license under Chapter 4101. Additionally, the Insurance Code §4151.1041(a) prohibits a carrier from knowingly referring a claim or loss for administration in this state to a person purporting to be or acting as an administrator, unless that person holds a certificate of authority under Chapter 4151. Section 4151.1041(b) requires a carrier to ascertain from the Commissioner whether the person performing the administration holds a certificate of authority under Chapter 4151 before referring a claim or loss for administration.

Confidentiality Concerns

Comment: One commenter objects to the definition of "Records" in proposed §7.1602(20) because it includes pleadings and investigatory files. The commenter contends that the definition should be revised to provide that a third-party administrator does not have to release records that are confidential, privileged, or proprietary in nature and requests that the definition in §7.1602(20) be revised to omit pleadings and investigatory files and to add "excluding records that are privileged, confidential, and proprietary in nature." To support the requested changes, the commenter states that in most cases, third-party administrators do not possess legal pleadings related to administrative law and legal proceedings and investigatory files associated with a claim as these documents are most often maintained by the law firm that represents the insurer or plan or private investigation firm that provides special investigation unit services to the insurer or plan. Another commenter recommends that the proposed rules contain a confidentiality provision that requires the Department to maintain any information it obtains or audits in a confidential manner and that such information

remain free from all disclosure to third party requirements. The commenter states that the proposed rules require that administrators and insurers provide many documents, records, and other information to the Department. The commenter states that many of the records or other information required to be provided will contain confidential and proprietary information, and that release of such information to third parties would raise serious competitive issues.

Agency Response: The Department declines to make the recommended changes. Section 7.1602(20) simply defines “Records” as written or electronic material directly or indirectly relating to the business of an administrator and provides some illustrative examples of material that may constitute records for purposes of the rules and the Insurance Code Chapter 4151. Section 7.1602(20) does not require an administrator to possess or maintain possession of pleadings or investigative files. If the administrator does not possess or maintain such files, that is of no consequence under these rules. A review of the rules that address an administrator’s records indicates that it is not within the ambit of these rules to determine what records are privileged, confidential, or proprietary in nature. The rules do not affect any of the laws that make any of the records privileged, confidential, or proprietary in nature. These rules include (i) §7.1612(f), which requires an administrator to properly maintain detailed accounting records that document all deposits and withdrawals from a fiduciary account; (ii) §7.1612(h), which provides that all records maintained by an administrator relating to any premium shall be subject to examination by the Commissioner upon request; (iii) §7.1613(e), which requires a written agreement entered into under §7.1613 to ensure that the books and records of the insurer remain the property of the insurer at all times,

and are available to the insurer or its designee at any time while in the custody of the administrator; (iv) §7.1615, which establishes requirements related to the timely transfer of the books and records of an insurer upon the termination of the relationship with the insurer; and (v) §7.1616(a)(4), which provides that failure to maintain records sufficient to permit examiners to determine an applicant's or administrator's financial condition or compliance with the Insurance Code, Labor Code, or rules adopted thereunder may be considered by the Department in determining whether an applicant or administrator is operating or conducting business in a potentially hazardous or injurious manner. The definition and use of the term "record" or "records" in the rules is consistent with the Insurance Code Chapter 4151, including §4151.006 relating to the Department's rulemaking authority; §4151.101 relating to the required written agreement with the insurer or plan sponsor; §4151.102 relating to the required contents of the written agreement; §4151.103(a) relating to the retention of the written agreement; §4151.103(d) relating to prescribing rules for the transfer of records from one administrator to another administrator; §4151.1042(a) relating to prescribing the administrator responsibilities in the written agreement; §4151.110 relating to prescribing the underwriting standards of the insurer or plan in the written agreement; §4151.257 relating to adopting rules to implement the requirements of Subchapter F, including rules prescribing requirements for contracts and master services agreements and requirements for the payment of claims; and §4151.301(11) relating to grounds for denial, revocation, or suspension of a certificate of authority. Additionally, the Department does not have the statutory authority to maintain in a confidential manner all information that it obtains or audits or to maintain such information in a way that is

free from all disclosure to third parties, as requested by one of the commenters. The Legislature has addressed the confidentiality of certain documents in the Insurance Code Chapter 4151, including §§4151.103(c), 4151.113(b), 4151.115(a), and 4151.205(e). Section 4151.103(c) provides that information the Commissioner or the Commissioner's designee obtains from the written agreement is confidential and may not be made available to the public. Section 4151.113(b) provides that a trade secret, including the identity and address of a policyholder, certificate holder, or injured employee, is confidential, except the Commissioner may use that information in a proceeding against the administrator. Section 4151.115(a) provides that information that identifies an individual covered by a plan is confidential. Section 4151.205(e) provides that information derived from an audited financial statement contained in an annual report under §4151.205 is confidential and is not subject to disclosure under Chapter 552, Government Code. The Department is subject to these confidentiality provisions, as well as other confidentiality provisions in Texas and federal statutes, and follows the provisions of the Government Code Chapter 551 regarding whether information is deemed public and subject to disclosure.

Comment: One commenter recommends that proposed §7.1609 be revised to provide that financial information submitted with an annual report is confidential as provided by the Insurance Code §4151.205(e).

Agency Response: The Department declines to make the suggested change. The Department disagrees that the Insurance Code §4151.205(e) deems all financial information submitted with an annual report to be confidential and not subject to disclosure under Chapter 552, Government Code. The Insurance Code §4151.205(e)

provides that "Information derived from an audited financial statement contained in an annual report" under the Insurance Code §4151.205 “is confidential and is not subject to disclosure under the Government Code Chapter 552.” The Department is subject to the confidentiality provision in the Insurance Code §4151.205(e), and thus, will treat information derived from an audited financial statement contained in an annual report as confidential and not subject to disclosure under Chapter 552, Government Code. If the Department receives an open records request for information derived from an audited financial statement contained in an annual report or the audited financial statement itself, the Department will obtain a determination from the Office of the Attorney General regarding whether to release or not release the requested information. Also, under the Insurance Code §4151.113(b), trade secrets, claimed by third party administrators, including the identity and addresses of policyholders and certificate holders, are confidential, except the Commissioner may use that information in a proceeding against a third party administrator. If the Department receives an open records request for information that an administrator has claimed a proprietary or privacy interest in (e.g., trade secret), the Department will obtain a determination from the Attorney General's office regarding whether to release or not release the information to the requestor. The Department also will send a letter, in a form required by the Attorney General, to the administrator notifying the administrator of the request and explaining the process for making arguments to the Attorney General.

Public Benefit/Cost Note: Anticipated Public Benefits

Comment: One commenter disagrees with the Department's discussion of the "anticipated public benefits" on pages 59 - 60 of 158 of the proposal published in the *Texas Register* on December 5, 2008, (33 TexReg 9904) which, according to the commenter, characterizes the multiple licensure requirements for applicants as "more efficient and standardized" (page 59) or "more efficient and consistent regulation of the industry" (page 60). This commenter contends that a more efficient and standardized process would be using existing certifications in lieu of requiring new and duplicative registration and licensure requirements.

Agency Response: The Department disagrees with the commenter's characterization that the Department stated or implied in the proposal that the multiple licensure requirements for applicants are "more efficient and standardized" (page 59) or "more efficient and consistent regulation of the industry" (page 60). The statement on page 59 specifies that "The anticipated public benefits include: (i) a more efficient and standardized process for regulating administrators, resulting in ease of operations and processes for the industry and the Department;. . . ." Page 60 of the proposal states in relevant part that: "The proposal also **clarifies the requirements of Chapter 4151 for persons holding other authorizations issued under the Insurance Code or the Labor Code**. This clarification is particularly significant because a person may be simultaneously subject to the requirements of different provisions of the Insurance Code, the Labor Code, or rules adopted thereunder based upon the diversity of the functions performed by that person. In such situations, a person may be required to hold one or more authorizations issued under the Insurance Code or the Labor Code in order to perform those regulated functions. **By providing additional guidance to**

applicants and administrators regarding their obligations under Chapter 4151, it is anticipated that a greater number of applicants and administrators will comply with the requirements of the Insurance Code, the Labor Code, and rules adopted thereunder. This should result in more efficient and consistent regulation of the industry." (emphasis added). These statements simply indicate that the proposed rules will result in a more efficient, consistent, and standardized process for regulating administrators and the industry, in part, by clarifying the requirements of Chapter 4151 for persons holding other authorizations issued under the Insurance Code or the Labor Code.

Public Benefit/Cost Note: Adequacy of Cost Note for Operational Review and On-Site Audit Requirements in §7.1611

Comment: A commenter disputes the adequacy of the part of the cost note outlining the anticipated costs of the semi-annual operational reviews and biennial on-site audits of administrators required by proposed §7.1611. The commenter expresses appreciation for the flexibility the proposed rule would allow for the location of the operational reviews and for the provision that would allow a member of the insurer's staff to conduct an on-site audit. However, the commenter expresses concern that the requirements for these reviews and on-site audits will result in unnecessary extra costs. The commenter points out that page 93 of the proposal states that the "department anticipates" that a member of the insurer's management staff could complete a review of an administrator in less than four hours and that a member of the insurer's staff could complete an on-site audit in a minimum of eight hours. According to the commenter,

the cost for an insurer's operational review or on-site audit of an administrator would result in higher overall expenses than stated in the cost note. The commenter estimates that each operational review and on-site audit would require a minimum of 40 hours on average and would require travel to the administrator's offices. The commenter's estimated cost for each on-site audit and operational review that requires travel to the administrator's offices is a "conservative" estimate of $5,076.

Agency Response: The Department disagrees that its cost estimates and relevant cost factors for the required semi-annual reviews and biennial on-site audits were underestimated for the following reasons. First, while the commenter correctly points out that page 93 of the proposal states that the Department anticipates that a member of an insurer's management staff could typically complete a review of an administrator in less than four hours and that a member of the insurer's staff could complete an on-site audit in a minimum of eight hours, the Department's cost note also clearly and unambiguously states that the probable costs of compliance with proposed §7.1611 would vary substantially among insurers depending upon several factors. These factors, as listed in the cost note, are: (i) the number of administrators the insurer is required to review and audit; (ii) the size and complexity of the organization of each administrator the insurer is required to review and audit; (iii) the number of hours an insurer needs to review a particular administrator's information; (iv) the adequacy of each administrator's books and records; (v) whether an administrator's internal controls are adequate; (vi) whether the insurer is already reviewing and auditing a particular administrator; (vii) whether the insurer is able to review the administrator through electronic means; and (viii) whether an insurer discovers substantial problems during a

review or audit, including the depth and complexity of those problems. Moreover, the Department stated in the proposal that its estimated costs may increase substantially depending upon whether a particular insurer discovers problems during a particular review or on-site audit that requires additional review and attention. Second, the Department's cost note also states that the §7.1611 review and on-site auditing requirements are consistent with prudent business practices. Therefore, the Department did not anticipate that most insurers utilizing the services of an administrator would need to make significant changes to their current review and auditing methods, systems, practices, and procedures. Third, the Department's cost note indicates that certain insurers may already have certain review or auditing procedures in place that meet all or the majority of the §7.1611 requirements. Fourth, the Department's cost note points out that §7.1611 does not dictate the precise methods, practices, systems, or procedures that must be utilized by an insurer during its review or on-site audit of an administrator. Therefore, §7.1611 provides each insurer with the flexibility to use the most economical means of compliance with the §7.1611 requirements. Fifth, the Department's cost note explains that §7.1611 provides options for compliance with the various requirements. Therefore, insurers are able to select options that will result in less costs being expended. For example, the insurer can perform the operational review through electronic means. Also, §7.1611(a) permits an insurer to conduct a review of an administrator on its own premises or at another designated location. This allows an insurer to choose the most economical location for performing its review. Section 7.1611(c) permits an insurer to forego one operational review of an administrator in the same fiscal year in which the insurer conducts an on-

site audit of the same administrator pursuant to §7.1611(b). This will reduce the number of reviews required and thus decrease the costs of those reviews. Another option for compliance is in §7.1611(f), which permits an on-site audit to be conducted by an insurer or an insurer's designated representative. Because the requirements as proposed did not require an on-site audit to be conducted by an actuary or an independent CPA, the cost note indicated that an insurer could use its own employees to conduct an on-site audit. This will also result in costs savings. Additionally, §7.1611(g) allows an insurer to forego an additional review and on-site audit of an administrator subcontractor under two specific circumstances: (i) the review and on-site audit of the administrator contractor contains adequate information about the administrator subcontractor; and (ii) there is no evidence of material non-compliance by the administrator subcontractor. This option will result in fewer reviews and audits and thus result in costs savings for insurers. Sixth, the Department has considerable experience with conducting reviews and on-site examinations of insurers, including a review of the totality of their operations, financial condition, and business operations. These reviews and examinations of insurers are considerably more substantial, complex and time-consuming than the reviews and operations required by §4151.1042(c) and §7.1611. The Department, however, because of similar cost factors, was able to rely on this experience to develop probable anticipated costs and relevant cost factors for persons to comply with proposed §7.1611. Finally, the Department clearly states in the proposal cost note that each insurer has the information necessary to estimate its own compliance costs. Therefore, the Department believes that the

commenter's objection is without basis because the commenter did not take into account all of the relevant cost estimate factors in the cost note for proposed §7.1611.

The commenter's own cost estimate for conducting both operational reviews and on-site audits is overstated because it includes one week's worth of related travel and lodging expenses for operational reviews. Section 7.1611 of the rule does not require on-site travel for operational reviews. As previously explained, §7.1611 includes several options to give insurers flexibility to reduce their costs of compliance, including the ability to conduct reviews at any location and by electronic means, which is intended to eliminate required travel costs and reduce the overall costs of the reviews. Similarly, §7.1611 does not require that the totality of an audit be conducted on-site at an administrator's place of business. Rather, the Department anticipates that a significant amount of preparatory and other work could be performed either before or after the on-site presence at an administrator's place of business. As stated in §7.1611(e), the purpose of the on-site audit required by §7.1611(b) is to verify the accuracy, integrity, and completeness of the information received during a review conducted by the insurer pursuant to §7.1611(a). In addition to the requirements in §7.1611(d), an on-site audit conducted by a insurer under §7.1611(b) must also include a physical inspection of the administrator's place of business and a written assessment of the reliability of the information provided to the insurer and relied upon by the insurer when conducting a review or on-site audit of the administrator under §7.1611. More specifically, §7.1611 requires certain incremental work that is specified in §7.1611(e) be conducted on-site at an administrator's place of business. However, allowing a significant amount of the work to be performed either before or after the on-site component of an audit will also

assist in reducing the costs of compliance. Finally, many, if not most, of the costs concerning operational reviews and on-site audits are the result of the legislative enactment of the Insurance Code §4151.1042 operational review and audit requirements, rather than the result of the requirements in these rules.

Definition of the Term "Administrator" in §7.1602(1) and Use of the Terms "Administrator Contractor" and "Administrator Subcontractor"

Comment: One commenter objects to all references to the terms "administrator contractor" and "administrator subcontractor" in the rules, including in proposed §7.1602(1), (3), and (4), proposed §7.1603(b), and proposed §7.1611(g), because the terms are confusing, overly burdensome, and beyond the scope of the enabling statutes in the Insurance Code Chapter 4151. Three other commenters object to the definition of "administrator" in proposed §7.1602(1) because it is overly broad, unclear, or exceeds the Department's rulemaking authority by including the terms "administrator contractors" and "administrator subcontractors." One commenter requests that the Department delete proposed §7.1603(b) and remove all references to "contractors" and "subcontractor" in proposed §7.1611(g) and limit the obligations of the insurer to inspection of "administrator," and either: (i) remove all references to "administrator contractor" and "administrator subcontractor" in the rules and use the definition of "administrator" provided in the Insurance Code §4151.001(1); (ii) remove all references to "administrator contractor" and "administrator subcontractor" in the rules and amend the definition of "administrator" to state "a person . . . who, under contract or subcontract, makes discretionary decisions on behalf of an insurer, plan, or plan

sponsor of ultimate claim acceptance and/or settlement. . . .”; or (iii) at a minimum, clarify each definition for “administrator contractor” and “administrator subcontractor” by stating that it “excludes entities that, under contract or subcontract, do not make discretionary decisions on behalf of an insurer, plan, or plan sponsor of ultimate claim acceptance and/or settlement. The reasons provided by the commenter to support its objections and requested changes are: (i) “administrator contractors” and “administrator subcontractors,” as those terms are defined in proposed §7.1602(3) and (4), and the duties performed by contractors and subcontractors, fall within the exception of the Insurance Code §4151.002(14), in that they are clearly providing the specified services to the administrator under contract, and the Department itself recognizes that it is the administrator, on behalf of the insurer, who is ultimately responsible for making the management and discretionary decisions, referencing the Insurance Code §4151.1042(a) and the preamble section of the proposal at page 33 of 158 ("each insurer retains the ultimate responsibility for all of its delegated duties, regardless of whether they are performed by an administrator contractor or an administrator subcontractor"); (ii) to give the exception in the Insurance Code §4151.002(14) its plain meaning, the definitions of “contractor” and “subcontractor” must be eliminated from the final rule, citing the Government Code §311.011(a), which provides that words and phrases shall be read in context and construed according to the rules of grammar and common usage; (iii) the definition of “administrator” in the Insurance Code §4151.001(1) only includes or defines two types of delegated entities to which the provision applies (delegated entities under the Insurance Code Chapter 1272 and certified workers’ compensation networks under the Insurance Code Chapter

1305), citing case law (*State v. Mauritz-Wells Co*., 175 S.W.2d 238, 241 (Tex. 1943): "It is a settled rule that the express mention or enumeration of one . . . thing . . . is equivalent to an express exclusion of all others."); (*Harris County v. Dowlearn*, 489 S.W.2d 140, 146 (Tex. Civ. App.-Houston [14th Dist.] 1972, writ ref'd n.r.e.) (same); and (iv) the Department confirmed that it does not intend to regulate contractors and subcontractors in a November 4, 2008 meeting when it represented that it is not the Department's intent to regulate anyone other than someone performing an adjusting function. The commenters objecting to the definition of "administrator" in proposed §7.1602(1) state that the proposed definition: (i) does not follow the definition of "Administrator" in the Insurance Code §4151.001(1) because it adds the sentence "The term includes administrator contractors and administrator subcontractors"; the Department does not have the authority to modify or amend the statutory definition of the term through rule-making, and the commenter cites case law to support this assertion (*Cruse v. Texas Department of Transportation*, 2007 WL 1345433 (Tex. App. – Amarillo May 8, 2007, no pet.) and *Hollywood Calling v. Public Utility Commission*, 805 SW 2d 618 (Tex. App., 1991)); (ii) is unclear and needs to be limited to a person that has the authority to manage a claim payment account or fiduciary bank account or that has management authority to oversee the adjusting and settling of claims on behalf of an insurer; and (iii) is overly broad and could lead to confusion about what entities are considered, by law, to be administrators or result in possible inadvertent violations by carriers and/or vendors. One of these commenters recommends amending the definition of "administrator" in proposed §7.1602(1) by deleting the sentence "The term includes administrator contractors and administrator subcontractors." Another

commenter recommends that the Department amend the definition of “administrator” in proposed §7.1602(1) to state: “As defined in the Insurance Code §4151.001(1). For purposes of workers’ compensation claims, an administrator is the person that has the authority to manage a claim payment account or fiduciary bank account or that has the management authority to oversee the adjusting and settling of claims on behalf of an insurer. The term does not include a person described by the Insurance Code §4151.002 or §4151.0021.” According to this commenter, the rules need to be clear regarding whether all ancillary service providers ("administrator subcontractors") who have a role in "adjusting" or "settling" a claim will be considered to be administrators, and thus apparently required to have written contracts with insurers or administrators, to obtain certificates of authority issued under proposed §7.1603(b), and to undergo on-sight audits under proposed §7.1611. Otherwise, the commenter contends, the range of “persons” that will be required under these rules to obtain a certificate of authority is exceedingly broad. The commenter further asserts that there is no public benefit in requiring subcontractors to obtain a certificate of authority, unless in fact an administrator subcontracts to another person the authority to manage a claim payment account or other fiduciary bank account or to manage and oversee the adjusting and settling of claims on behalf of an insurer. This commenter further contends that on-sight audits of these ancillary providers will add little value to the regulatory process and will be very costly.

Agency Response: The Department declines to make the requested changes for the following reasons.

Definitions of "administrator," "administrator contractor," and "administrator subcontractor" and use of these terms in the rules are not confusing, unclear, overly burdensome, overly broad, beyond the scope of Chapter 4151, or in excess of the Department's rulemaking authority. The Department disagrees that the definitions and use of the terms "administrator contractor" and "administrator subcontractor" in the rules, including in proposed §7.1602(1), (3) and (4), proposed §7.1603(b), and proposed §7.1611(g), are confusing, overly burdensome, or beyond the scope of the provisions of the Insurance Code Chapter 4151. The Department disagrees that the definition of "administrator" in proposed §7.1602(1), which includes administrator contractors and administrator subcontractors, exceeds the Department's rulemaking authority, is overly broad, or unclear. The Department understands that because HB 472 for the first time brings all workers' compensation administrators into the regulatory framework of Chapter 4151 and under the regulatory purview of the Department that initially the rules and the statute may appear confusing. However, when the rules are read in their entirety and in conjunction with Chapter 4151, the meaning and consistency of the terms "administrator," "administrator contractor," and "administrator subcontractor" with the statute become clear. The use and definitions of the terms "administrator," administrator contractor," and "administrator subcontractor" in these rules are applied consistently with the provisions of the Insurance Code Chapter 4151. The definition of the term "administrator" in §7.1602(1) is "as defined in the Insurance Code §4151.001(1). The term includes administrator contractors and administrator subcontractors. The term does not include a person described by the Insurance Code §4151.002 or §4151.0021." The term "administrator contractor" is defined in §7.1602(3)

as “an administrator as defined in the Insurance Code §4151.001(1) who contracts or enters into an agreement with an administrator subcontractor for the performance of all or a portion of the administrative services the administrator contractor previously agreed to perform on behalf of an insurer, HMO, plan sponsor, or group. The term does not include a person described by the Insurance Code §4151.002 or §4151.0021.” The term “administrator subcontractor” is defined in §7.1602(4) as “an administrator as defined in the Insurance Code §4151.001(1) who contracts or enters into an agreement with an administrator contractor for the performance of all or a portion of the administrative services the administrator contractor previously agreed to perform on behalf of an insurer, HMO, plan sponsor, or group. The term does not include a person described by the Insurance Code §4151.002 or §4151.0021.” The definitions of the terms “administrator contractor” and “administrator subcontractor” in §7.1602(3) and (4) clarify that contractors or subcontractors who perform or offer to perform the acts of an administrator are also considered *administrators* for purposes of the Insurance Code Chapter 4151 and these rules. Therefore, if an administrator (Administrator A) contracts or enters into an agreement with another administrator (Administrator B), as that term is defined in the Insurance Code §4151.001(1) and §7.1602(1), to perform all or any part of the administrative services that Administrator A previously agreed to perform on behalf of an insurer, HMO, plan sponsor, or group, Administrator B is an “administrator subcontractor” as defined in §7.1602(4). Administrator A under this scenario would be considered an “administrator contractor” as defined in §7.1602(3). Therefore, under §7.1611(g), relating to operational review and on-site audit, an insurer may meet the requirements of §7.1611 for an administrator subcontractor (Administrator B) by

reviewing and auditing the administrator contractor (Administrator A) only, provided that (i) the information supplied to the insurer by the administrator contractor (Administrator A) includes all necessary and relevant information relating to the administrator subcontractor (Administrator B); and (ii) no evidence of material non-compliance by the administrator subcontractor (Administrator B) exists. Also, under §7.1613(b), relating to written agreements between administrators and insurers, an administrator subcontractor (Administrator B) may meet the requirements of §7.1613 by entering into a written agreement with the administrator contractor (Administrator A) only, provided the written agreement meets the requirements of the Insurance Code Chapter 4151 and §7.1613, as applicable. Under §7.1615(e), relating to transfer of books and records, if a relationship between an administrator subcontractor (Administrator B) and an administrator contractor (Administrator A) terminates, the administrator subcontractor (Administrator B) may meet the requirements of §7.1615 by: (i) providing a complete and accurate original set or a complete and accurate copy or image of the original set of the insurer's, HMO's, plan sponsor's, or group's books and records to the administrator contractor (Administrator A); and (ii) providing written notice to the Department of the termination of the relationship or written agreement with the administrator contractor (Administrator A) no later than 30 days from the date the administrator subcontractor (Administrator B) first learns of the termination.

For the preceding reasons as well as the following reasons, the Department also disagrees that the definitions and use of the terms "administrator," "administrator contractor," and "administrator subcontractor" in the rules are overly burdensome or beyond the scope of the provisions of the Insurance Code Chapter 4151. The

definitions in proposed §7.1602(1), (2), (3) and (4), which are adopted without changes, are consistent with the Department's rulemaking authorization in (i) §4151.006 to adopt rules that fairly, reasonably, and appropriately augment and implement the Insurance Code Chapter 4151, including rules to establish financial standards, reporting requirements, and required contract provisions; (ii) §4151.101(b) to adopt rules to prescribe provisions that must be included in the written agreement with an insurer or plan sponsor; (iii) §4151.103(d) to adopt rules to address the transfer of records from one administrator to another; and (iv) §4151.257 to adopt rules to implement the requirements of the Insurance Code Chapter 4151, Subchapter F, including rules prescribing requirements for contracts and master services agreements and requirements for the payment of claims. The definitions are consistent with the statutory provisions and general objectives of the Insurance Code Chapter 4151, including but not limited to §§4151.001, 4151.002, 4151.0021, 4151.006, 4151.051, and 4151.1042. For consistency with the statutory definition of "administrator" in §4151.001(1), the definitions of "administrator" in §7.1602(1), "administrator contractor" in §7.1602(3), and "administrator subcontractor" in §7.1602(4) reference the §4151.001(1) definition of the term "administrator." For consistency with the exemptions specified in §4151.002 and §4151.0021, the §7.1602(1), (3), and (4) definitions state that the term does not include a person described by the Insurance Code §4151.002 or §4151.0021. The definition in §7.1602(1) also clarifies that the term "administrator" includes "administrator contractors" and "administrator subcontractors," which are defined in §7.1601(3) and (4). This clarification is necessary because under Chapter 4151 persons who are administrators who contract out their administrative services that are subject to

regulation under Chapter 4151 (administrator contractors) and persons who agree to perform such administrative services (administrator subcontractors), i.e., persons that act as or hold themselves out as administrators and meet the definition of "administrator" in §4151.001(1), are regulated pursuant to Chapter 4151 and these rules. The terms "administrator contractor" and "administrator subcontractor" are defined in §7.1601(3) and (4) to be an administrator as defined in the Insurance Code §4151.001(1) and a person not meeting an exemption described in §4151.002 or §4151.0021. Thus "administrator contractors" and "administrator subcontractors" are defined consistently with §4151.001(1), and therefore, necessarily must be regulated as administrators for purposes of Chapter 4151 and these rules. Additionally, neither the Insurance Code Chapter 4151 nor these rules prohibit the delegation of an administrative service from one administrator to another administrator or exclude contractors or subcontractors who act or hold themselves out as administrators, as that term is defined in §4151.001(1), from regulation under Chapter 4151. Because there are no statutory or regulatory prohibitions concerning the delegation of an administrative service, an administrator has the option to delegate the authority to perform some or all of its administrative services or functions to an administrator subcontractor. Accordingly, the Department has received questions about whether an administrator under the Insurance Code 4151 that subcontracts with another person to perform the services of an administrator as described in the Insurance Code §4151.001(1) is also considered an "administrator" under the Insurance Code Chapter 4151. Consequently, the Department has determined that it is necessary and appropriate to clarify the regulation of such persons under these rules. Since the Insurance Code Chapter 4151

(formerly Article 21.07-6), became effective on September 1, 1989, the Department has interpreted Chapter 4151 to mean that a person who contracts with a Chapter 4151 administrator to perform the services of the administrator as described in §4151.001(1), i.e., subcontractor, is also considered an “administrator” under the Insurance Code Chapter 4151. The definitions and use of the terms “administrator contractor” and “administrator subcontractor reflect the Department’s long-standing practice and application of the definition of “administrator” in the Insurance Code §4151.001(1) in combination with the other provisions of Chapter 4151, including the exemptions enumerated in the Insurance Code §4151.002 and §4151.0021. Significantly, the Insurance Code §4151.051 expressly provides that “An individual, corporation, organization, trust, partnership, or other legal entity may not act as or hold itself out as an administrator unless the entity is covered by and is engaging in business under a certificate of authority issued under this chapter.” Therefore, an administrator contractor or administrator subcontractor as defined in §7.1602(3) and (4) that also is an individual, corporation, organization, trust, partnership, or other legal entity acting as or holding itself out as an administrator is required to have a certificate of authority issued under Chapter 4151. Because an administrator contractor or administrator subcontractor as defined in §7.1602(3) and (4) necessarily is considered an “administrator” under Chapter 4151 and the rules, an administrator contractor or administrator subcontractor is acting as an administrator, as contemplated under §4151.051. Accordingly, §7.1603(b) is necessary to clarify that both an administrator contractor and an administrator subcontractor are required to hold a certificate of authority under the Insurance Code Chapter 4151. Furthermore, if an individual, corporation, organization,

trust, partnership, or other legal entity is holding itself out as an administrator contractor or administrator subcontractor as defined in §7.1602(3) and (4), this legal entity also is required to hold a certificate of authority under the Insurance Code Chapter 4151 and §7.1603(a).

In addition to the preceding reasons, the Department disagrees for the following additional reasons that the definition of “administrator” in proposed §7.1602(1), which includes administrator contractors and administrator subcontractors, exceeds the Department’s rulemaking authority, is overly broad, or unclear. An analysis of the rule provisions in which the terms “administrator contractor” and “administrator subcontractor" are used and the applicable case law support this position. First, the inclusion of the terms do not impose any additional burdens, conditions, or restrictions on a person, including an administrator or insurer, beyond or inconsistent with the Insurance Code Chapter 4151. To the contrary, as previously stated, the terms “administrator,” administrator contractor,” and “administrator subcontractor” in these rules are applied consistently with the provisions of the Insurance Code Chapter 4151. These rule provisions are necessary to regulate persons that act or hold themselves out as administrators in situations where such persons further delegate the performance of an administrative service to another person acting or holding itself out as administrator as defined in Chapter 4151. Because the terms “administrator contractor” and “administrator subcontractor” are defined as administrators under §4151.001(1) and not persons described in the statutory exemptions enumerated in §4151.002 or §4151.0021, the terms are within the ambit of the term “administrator” in accordance with the provisions of Chapter 4151. In addition to §7.1601(1), (3), and (4) that define

the terms “administrator,” “administrative contractor,” and “administrator subcontractor,” the terms “administrative contractor” and “administrator subcontractor” as used in the rules implement the following statutory provisions: (i) in §7.1603(b), to clarify and implement the Insurance Code §4151.051(a), relating to the certificate of authority requirements, in situations where an administrative service or function is delegated from one administrator to another administrator; (ii) in §7.1611(g), to clarify and implement §4151.1042(c), relating to operational review and on-site audit, by permitting an insurer to meet the requirements of §7.1611 for an administrator subcontractor by reviewing and auditing the administrator contractor only, provided that certain specified conditions are met; (iii) in §7.1613(b), to clarify and implement §§4151.006, 4151.101, 4151.102, 4151.103, 4151.110, 4151.253, and 4151.257, relating to written agreements, by permitting an administrator subcontractor to meet the requirements of §7.1613 by entering into a written agreement with the administrator contractor only, provided the written agreement meets the requirements of the Insurance Code Chapter 4151 and §7.1613, as applicable; and (iv) in §7.1615(e), to clarify and implement §4151.112, relating to transfer of books and records, by permitting an administrator subcontractor to meet the requirements of §7.1615 by complying with certain specified requirements in situations in which the relationship between an administrator subcontractor and an administrator contractor terminates. Therefore, the rules are in accordance with the legal principle that rules promulgated by an administrative agency may not impose additional burdens, conditions, or restrictions beyond or inconsistent with the statutory provisions. (See *Hollywood Calling v. Public Utility Commission*, 805 S.W. 2d 618 (Tex. App--Austin, 1991 *no writ*)).

Second, Chapter 4151 of the Insurance Code grants broad rulemaking authority to the Department. Section 4151.006 authorizes the Commissioner to adopt rules that are fair, reasonable, and appropriate to augment and implement this chapter, including rules establishing financial standards, reporting requirements, and required contract provisions. Section 4151.101(b) authorizes the Commissioner by rule to prescribe provisions that must be included in the written agreement required between an administrator and insurer or plan sponsor under §4151.101. Section 4151.103(d) requires the Commissioner to adopt rules to address the transfer of records from one administrator to another. Section 4151.257 requires the Commissioner to adopt rules to implement the requirements of the Insurance Code Chapter 4151, Subchapter F (relating to workers' compensation benefit plans), including rules prescribing requirements for contracts and master services agreements and requirements for the payment of claims. The rules promulgated under §4151.257 must provide for compliance with the requirements of the Insurance Code Chapter 4151 for any contract that takes effect or has an annual anniversary date on or after January 1, 2008. These statutes expressly grant the Department broad authority to regulate all persons acting or holding themselves out as administrators as defined in Chapter 4151, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers compensation benefits, regardless of whether these persons are also contractors or subcontractors. Thus, the particular statutory rulemaking provisions, which provide broad authorization to the Department to promulgate rules (e.g., §4151.006 which authorizes the Commissioner to adopt rules that are fair, reasonable, and appropriate to augment and implement Chapter 4151, including rules establishing

financial standards, reporting requirements, and required contract provisions), are a significant factor in determining whether the Department has exceeded its rulemaking authority. Additionally, the rule provisions relating to administrator contractors and administrator subcontractors clarify and implement the (i) certificate of authority requirements under §4151.051; (ii) notification and reporting requirements in §4151.052(b); (iii) written agreement or contracting requirements in §§4151.101, 4151.102, 4151.103(a), 4151.1042(a), 4151.110, and 4151.257; and (iv) oversight and monitoring requirements in §4151.1042. (See *Hollywood Calling at 620:* In making a determination as to whether a rule promulgated by an administrative agency exceeds the authority of the agency, the reviewing court must look not only to particular provisions to but all applicable provisions.)

Third, no provisions in the Insurance Code Chapter 4151 limit or restrict the Department's broad authority, powers, and duties to regulating only those persons acting or holding themselves out as administrators who do not delegate the performance of an administrative service to another person acting or holding itself out as administrator as defined in Chapter 4151. Furthermore, as previously stated, no provisions in Chapter 4151, including the exemptions in §4151.002, prohibit the delegation of an administrative service from one administrator to another administrator or exclude contractors or subcontractors who act or hold themselves out as administrators, as that term is defined in Chapter 4151, from regulation under Chapter 4151 as administrators.

Fourth, moreover, the Department's positions and interpretations as previously described in this response are consistent with other case law interpreting an agency's

administrative authority, including *Hammack v. Public Utility Commission of Texas*, 131 S.W. 3d 713, 723 (Tex. App.--Austin, 2004, *no pet.*) in which, according to the court "Because administrative agencies are given their statutory powers with a view to achieving legislative purposes more fully and effectively through the agency's specialized judgment, knowledge, and experience, the methods chosen by the agency, and its interpretation of the statute it is required to administer, are entitled to judicial respect." (emphasis added.) Also, according to *Gulf Coast Coalition of Cities v. Public Utilities Commission of Texas,* 161 S.W. 3d 706, 712 (Tex.App.--Austin 2005, *no pet.*), courts consider "the rule as a whole and in relationship to the statute which it implements. . . When there is . . . or room for policy determinations, the reviewing court defers to an administrative agency's interpretation unless it is plainly inconsistent with the language of the rule under review."

Fifth, therefore, not only are the rule provisions that define and use the terms "administrator contractor" or "administrator subcontractor" in harmony with, and not contrary to, the statutory provisions of the Insurance Code Chapter 4151, the use of these terms are also consistent with the general objectives of Chapter 4151, as amended by HB 472. According to the legislative bill analysis for HB 472, one of the main objectives is bring all workers' compensation administrators into the regulatory framework of Chapter 4151 and under the regulatory purview of the Department. (TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Committee Report, Amended), HB 472, 80th Legislature, Regular Session (May 15, 2007)). To ensure that all such administrators, including contracting administrators (administrator contractors) and those they contract with (administrator subcontractors) that perform Chapter 4151

administrative functions are appropriately regulated under Chapter 4151, it is necessary to include such persons under the regulation of these rules. The inclusion of the terms "administrator contractor" and "administrator subcontractor" in the rules, including in the definition of "administrator in §7.1602(1), makes it absolutely clear that all administrators, including administrator contractors and administrator subcontractors, are required to comply with the requirements of the Insurance Code Chapter 4151 and the new rules and will ensure appropriate oversight and more efficient regulation of all administrators. Administrative agencies generally possess by implication such powers as may be necessary to effectuate the legislative objectives which underlie the administrative powers expressly conferred upon them. (See *Hammack* at 723*.)* This will assist in fulfilling the purpose to better protect the interests of the public and insurance consumers in this state.

Section 4151.002(14) does not require that the terms "administrator contractors" and "administrator subcontractors" be eliminated from the rules. The Department disagrees with the commenter that "administrator contractors" and "administrator subcontractors," as those terms are defined in proposed §7.1602(3) and (4), and adopted without change, fall within the exception of the Insurance Code §4151.002(14), and that as such, the definitions must be eliminated from the final rule. The Department does not agree that this is necessary because of the Government Code §311.011(a), which provides that words and phrases shall be read in context and construed according to the rules of grammar and common usage. It is the Department's position that administrator contractors and administrator subcontractors as defined in these rules do not fall within the exception of the Insurance Code §4151.002(14). To the contrary,

the terms “administrator contractor” and “administrator subcontractor” are defined in §7.1602(3) and (4) necessarily to be “administrators” under the Insurance Code §4151.001(1) and to not be a person exempted by the Insurance Code §4151.0021 or §4151.002, including §4151.002(14). Thus, for a person to be considered an “administrator contractor” or an “administrator subcontractor” for purposes of Chapter 4151 and these rules, the person must meet these requirements. While it is possible that a particular entity or individual may be called a contractor or subcontractor in a context that is outside of the purview of these rules, the definitions in §7.1602(3) and (4) address only those contractors and subcontractors that are “administrator contractors” and “administrator subcontractors” for purposes of Chapter 4151 and these rules. Section 4151.002(14) provides that a person is not an administrator if the person provides technical, advisory, utilization review, precertification, or consulting services to an insurer, plan, or plan sponsor but does not make any management or discretionary decisions on behalf of the insurer, plan, or plan sponsor. Whether a person is an administrator contractor or an administrator subcontractor as defined in §7.1602(3) or (4), or instead meets the §4151.002(14) exemption, depends entirely upon the particular facts and circumstances involved, including the functions or services the person performs or offers to perform and the particular arrangements or agreements entered into between the parties involved. Under these rules, the Department will continue, in accordance with its long-standing and existing application of the definition of “administrator” in the Insurance Code §4151.001(1) in combination with the other provisions of Chapter 4151, to make fact-specific determinations on a case-by-case basis regarding whether a particular person is an administrator contractor or an

administrator subcontractor, considering such factors and circumstances as (i) the particular agreements or contracts entered into between the insurer, contractor, and/or subcontractor; (ii) the functions or services actually being performed or provided or offered to be performed or provided by the contractor and subcontractor; (e.g., whether either or both persons are collecting or offering to collect premiums or contributions from residents of this state, or adjusting, settling, or offering to adjust or settle claims for residents of this state, in connection with annuities or life, health, accident, pharmacy, or workers' compensation benefits); and (iii) whether the contractor and/or subcontractor meet an exemption under the Insurance Code §4151.002, including §4151.002(14).

Further, as previously stated in this response, because there is no statutory or regulatory prohibition concerning the delegation of an administrative service, an administrator contractor may choose to delegate the authority to perform some or all of its administrative services or functions to an administrator subcontractor. Also as previously stated, the delegated-to entity that is an individual, corporation, organization, trust, partnership, or other legal entity acting as or holding itself out as an administrator is required to have a certificate of authority issued under Chapter 4151. Therefore, in a situation where an “administrator,” as defined in the Insurance Code §4151.001 and adopted new §7.1602(1), delegates all or a portion of the administrative services or functions (e.g., collecting premium or contributions, or adjusting or settling claims) it previously agreed to perform on behalf of an insurer, HMO, plan sponsor, or group to another person meeting the definition of an administrator under the Insurance Code §4151.001(1) and new §7.1602(1), the delegating administrator is an “administrator contractor” and is so defined under adopted new §7.1602(3) while the administrator who

is delegated to is an “administrator subcontractor” and is so defined under adopted new §7.1602(4). Because both persons in this scenario meet the definition of “administrator” in §4151.001(1) and the adopted new §7.1602(1), these persons by definition are not persons meeting one of the exemptions enumerated in the Insurance Code §4151.002 or §4151.0021. Under this scenario, because both the administrator contractor and administrator subcontractor qualify as an administrator under adopted new §7.1602(1), both are required to comply with the Insurance Code Chapter 4151 and these rules, including the requirement to obtain and hold a certificate of authority under Chapter 4151.

More complex scenarios are presented in the following two illustrations to further demonstrate the Department’s position disagreeing with the commenter that the definitions of “contractor” and “subcontractor” must be eliminated from the final rule in order to give the exception in the Insurance Code §4151.002(14) its plain meaning. In Illustration A, an insurer (Insurer) enters an agreement with a person (Contractor No. 1) to delegate to Contractor No. 1 the discretionary or management authority to adjust or settle claims in connection with workers’ compensation benefits for residents of this state. Contractor No. 1 further delegates the performance of adjusting the amount of workers’ compensation medical benefits based upon a compensable injury to another person (Subcontractor No. 1) and further delegates the discretionary or management decision-making authority to Subcontractor No. 1 to adjust the amount of workers’ compensation medical benefits based upon a compensable injury. Contractor No. 1 further delegates the performance of adjusting the compensability issues, including the extent of the compensable injury, to another person (Subcontractor No. 2) and further

delegates the discretionary or management decision-making authority to Subcontractor No. 2 to adjust the compensability issues, including extent of the compensable injury. Subcontractor No. 1 adjusts the workers' compensation medical benefits using discretionary or management decision-making on behalf of the Insurer. Subcontractor No. 2 adjusts the compensability issues using discretionary or management decision-making on behalf of the Insurer. This scenario assumes that Contractor No. 1, Subcontractor No. 1, and Subcontractor No. 2 do not meet an exemption described in the Insurance Code 4151.002 or 4151.0021. Under this scenario, Contractor No. 1, Subcontractor No. 1, and Subcontractor No. 2 each meet the definition of an "administrator" under the Insurance Code §4151.001(1) and new §7.1602(1). Under §7.1601(3), Contractor No. 1 is also an "administrator contractor." Under §7.1601(4), Subcontractor No. 1 and Subcontractor No. 2 are both "administrator subcontractors." Additionally, under these particular circumstances, all three persons are subject to the requirements of the Insurance Code Chapter 4151 and these rules, including the requirement to hold a certificate of authority under the Insurance Code 4151 and new §7.1603.

In Illustration B, there is the same hypothetical situation as in Illustration A, except that Subcontractor No. 1 is not delegated either discretionary or management decision-making authority to adjust the workers' compensation medical benefits, and never adjusts or settles claims, collects premiums or contributions, or holds itself out as, adjusting or settling claims or collecting premiums or contributions for residents in this state in connection with life and annuity, accident, health, pharmacy, or workers' compensation benefits. Additionally, Subcontractor No. 1 only provides technical,

advisory, utilization review, precertification, or consulting services to an insurer, plan, or plan sponsor but does not make any management or discretionary decisions on behalf of the insurer, plan, or plan sponsor in the manner contemplated under the Insurance Code §4151.002(14). Under these particular circumstances in Illustration B, Subcontractor No. 1 does not meet the definition of "administrator" under the Insurance Code §4151.001(1), and therefore, is not an "administrator" under the Insurance Code §4151 or these rules. Subcontractor No. 1 is also not an "administrator subcontractor" under new §7.1602(4).

Department did not state or imply that "administrator contractors" and "administrator subcontractors," as defined in §7.1602(3) and (4) fall within the exception of the Insurance Code §4151.002(14). The Department disagrees that it at any time stated or implied agreement with the commenter's assertion that "administrator contractors" and "administrator subcontractors," as defined in §7.1602(3) and (4), fall within the exception of the Insurance Code §4151.002(14). On page 33 of 158 of the Department's proposal published in the *Texas Register* on December 5, 2008, the Department did not state or imply, as the commenter contends, that the administrator, on behalf of the insurer, is ultimately responsible for making the management and discretionary decisions. Rather, the Department stated that each "*insurer*" retains the ultimate responsibility for all of its delegated duties, regardless of whether they are performed by an administrator contractor or an administrator subcontractor. The page 33 discussion provides the background behind the Department's long standing position that a person that functions as an administrator in a manner that is required to obtain a certificate of authority under the Insurance Code Chapter 4151 must obtain such a

certificate of authority, regardless of whether that person is in a direct contractual relationship with an insurer or is a down-stream subcontractor who is delegated administrator functions from another administrator. Page 33 of 158 of the preamble of the proposed rules explains in pertinent part: "However, an administrator contractor ***may*** delegate a few, specific duties to an administrator subcontractor and ***may*** retain a contractual responsibility for the performance of those duties, despite the delegation of those duties to the administrator subcontractor. Additionally, some insurers ***may*** permit their administrator contractors to further delegate duties to administrator subcontractors, provided that the administrator contractors retain responsibility for the performance of those duties. As previously stated, each ***insurer*** retains the ultimate responsibility for all of its delegated duties, regardless of whether they are performed by an administrator contractor or an administrator subcontractor." (emphasis added) These explanations, which are made in the context of the contractual requirements mandated in §7.1613, illustrate just a few of the many possible variations that may exist among insurers, administrator contractors, and administrator subcontractors concerning contractual arrangements, and the scope of duties, responsibilities, and authority delegated (e.g., extent of delegated management or discretionary authority). Additionally, the Insurance Code §4151.1042(a) does not state or imply that "administrator contractors" or "administrator subcontractors," as those terms are defined in §7.1601, fall within the exception of the Insurance Code §4151.002(14). Nor does the Insurance Code §4151.1042(a) state or imply that an administrator, on behalf of the insurer, is ultimately responsible for making the management and discretionary decisions. Instead, the Insurance Code §4151.1042(a) sets forth the responsibilities of an insurer if it uses the

services of an administrator, as defined in the Insurance Code §4151.001(1). Specifically, §4151.1042(a) provides that "If an insurer uses the services of an administrator, the insurer is responsible for determining the benefits, premium rates, reimbursement procedures, and claims payment procedures applicable to the coverage and for securing reinsurance, if any. The insurer shall provide a copy of the written requirements relating to those matters to the administrator. The responsibilities of the administrator as to any of those matters must be set forth in the written agreement between the administrator and the insurer."

Definition of "administrator" in the Insurance Code §4151.001(1) does not only include or define two types of delegated entities. The Department does not agree that the definition of "administrator" in the Insurance Code §4151.001(1) only includes or defines two types of delegated entities to which the provision applies (delegated entities under the Insurance Code Chapter 1272 and certified workers' compensation networks under the Insurance Code Chapter 1305). This comment is based on the sentence in the Insurance Code §4151.001(1) that states "The term includes a delegated entity under Chapter 1272 and a workers' compensation health care network authorized under Chapter 1305 that administers a workers' compensation claim for an insurer, ..." This sentence does not, as the commenter contends, limit the definition of "administrator" to only the two types of entities listed, nor exclude all other "administrator contractors" or "administrator subcontractors" that are not one of these listed entities. Under the commenter's reasoning, the only persons that could ever meet the definition of "administrator" in the Insurance Code §4151.001(1) would be a delegated entity under the Insurance Code Chapter 1272 or a workers' compensation health care network

authorized under the Insurance Code Chapter 1305. This interpretation is not valid for several reasons. First, this construction is not consistent with the objectives of HB 472 as explained in the legislative bill analysis for HB 472. According to the bill analysis, one of the main objectives is to include workers' compensation administrators into the regulatory framework of Chapter 4151 and under the regulatory purview of the Department. (TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Committee Report, Amended), HB 472, 80th Legislature, Regular Session (May 15, 2007)). This language clearly intends that more than just workers' compensation networks authorized under the Insurance Code Chapter 1305 constitute the total extent of the objective. Secondly, a plain reading of the Insurance Code Chapter 4151, as amended by HB 472, does not support this reasoning. For example, it is not reasonable that the definition of "administrator" in the Insurance Code §4151.001(1) when read in conjunction with other provisions of Chapter 4151, limit the definition of administrator to only the two types listed by the commenter. For example, §4151.051(a) prohibits any individual, corporation, organization, trust, partnership, or other legal entity from acting or holding itself out as an administrator unless the entity is covered by and is engaging in business under a certificate of authority issued under Chapter 4151. Clearly, the broad language of §4151.051(a) cannot be interpreted to limit the definition of administrator to only the two types listed by the commenter. Also, §4151.151 contemplates a "pharmacy benefit manager" as another type of delegated entity that is an administrator for purposes of the Insurance Code Chapter 4151. Thirdly, the commenter's interpretation ignores the first sentence in §4151.001(1) and the use of the word "person" in that sentence. The first sentence states that "Administrator" means "a

person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state." The Insurance Code §4151.001(3) defines the term "person" very broadly as "an individual, partnership, corporation, organization, government or governmental subdivision or agency, business trust, estate trust, association, or any other legal entity." Therefore, the definition of "administrator" in §4151.001(1) must encompass more than just "a delegated entity under Chapter 1272 and a workers' compensation health care network authorized under Chapter 1305 that administers a workers' compensation claim for an insurer." It is not reasonable that the second sentence in §4151.001(1) that the commenter relies on renders the first sentence meaningless. The fourth reason is that the use of the term "includes" is a term of enlargement and not of limitation. For example, see Gov't Code §311.005(13), which defines the terms "includes" and "including," and *Jackson v. Chappell*, 37 S.W. 3d 15, 25-26 (Tex. App.--Tyler, 2000, *no pet.*) holding that "Construing the statute with the aid of the Code Construction Act, "includes" and "including" are "terms of enlargement and not of limitation or exclusive enumeration, and use of the terms does not create a presumption that components not expressed are excluded." Therefore, the use of the term "includes" in the second sentence in §4151.001(1) cannot be interpreted to exclude other persons that are not expressed.

Department did not represent that the intent is to regulate only someone performing an adjusting function. The Department disagrees that it stated or implied in a November 4, 2008 meeting (or at any other time) that it is the Department's intent to

regulate only those performing an adjusting function and thereby confirmed that the Department does not intend to regulate contractors and subcontractors. Instead, Department staff stated in that meeting that the Department is not looking at requiring certificates of authority to act as administrators from persons in the workers' compensation business unless the persons are performing the acts of an administrator or holding themselves out as administrators.

Definition of "Administrative Services" in §7.1602(2)

Comment: One commenter objects to the definition of "administrative services" in proposed §7.1602(2) because the definition is overly broad. The commenter recommends revising the definition of "administrative services" to read: "Claims management and adjudication services offered or performed by an administrator."

Agency Response. The Department disagrees that the term "administrative services" in §7.1602(2) is overly broad and declines to adopt the commenter's suggested change. The commenter's recommendation to replace the proposed definition for "administrative services" in §7.1602(2) to read "Claims management and adjudication services offered or performed by an administrator" is not consistent with the definition of "Administrator" in §4151.001(1) of the Insurance Code. Section 4151.001(1) defines the term "Administrator" to mean a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. Section 7.1602(2), which is adopted without change to the proposed text, defines "administrative services" to mean "Services offered or performed

by an administrator." This definition in §7.1602(2) is consistent with the definition of "Administrator" in §4151.001(1) and is therefore the more appropriate definition for the purposes of these rules. The additional reasons for the Department's disagreement with the commenter are the following. First, the term "administrative services" as used in these rules simply refers to an administrator's functions in a generic sense. Second, an analysis of the rule provisions in which the term is used indicates that the term does not impose any additional burdens, restrictions, conditions, or requirements on a person who is an administrator that is in addition to those functions which the administrator has agreed to perform. These rule provisions that use the term "administrative services" are (i) §7.1601(b) to clarify the scope of the rules to require, in accordance with the Insurance Code §1272.058 and the Labor Code §407A.009, an administrator performing administrative services on behalf of an HMO or a workers' compensation self-insurance group to meet the same requirements under the Insurance Code Chapter 4151 and this subchapter as an administrator performing administrative services on behalf of an insurer or plan sponsor; (ii) §7.1601(3) and (4) to define the terms "administrative contractor" and "administrator subcontractor"; (iii) §7.1602(15) to define the term "master services agreement"; (iv) §7.1609(d) to describe those who are exempt from audit report requirements specified in §7.1609(c); (v) §7.1613 to clarify the requirements for written agreements between administrators and insurers; (vi) §7.1614(5) to prohibit, pursuant to the Labor Code §415.0036, an administrator from offering to pay, paying, soliciting, or receiving an improper inducement relating to the delivery of benefits to an injured employee, if the administrator performs administrative services on behalf of a person who is a participant in the workers' compensation system

of this state; and (vii) §7.1614(6) to prohibit, pursuant to the Labor Code §415.0036, an administrator from improperly attempting to influence the delivery of benefits to an injured employee, including through the making of improper threats, if the administrator performs administrative services on behalf of a person who is a participant in the workers' compensation system of this state.

§7.1602(6). Definition of "Claim"

Comment: Two commenters object to the definition of "Claim" in proposed §7.1602(6) because it is unclear or overly broad for purposes of workers' compensation insurance. One commenter requests that the proposed definition be revised to read: "A demand for payment, services, or benefits under a plan. For the purposes of workers' compensation insurance, a claim is established when a loss occurs on a specific date of injury. A separate workers' compensation claim shall not be deemed to have occurred or been established when a claims action occurs within a claim established for a specific date of injury." The other commenter similarly recommends that there should be only one "claim" for workers' compensation purposes and should be limited to a report of an injury to an insurance carrier under the Labor Code §409.021. This second commenter recommends the definition be revised to state: "A demand for payment, services, or benefits under a plan. A claim for workers' compensation purposes is a report of injury under §409.021 of the Labor Code." The commenters' reason for the requested changes is that the proposed definition does not take into account that in the Texas workers' compensation system, a claim is established when a loss occurs on a specific date known as the "date of injury," and not for each claim transaction that

occurs during the “life” of a workers' compensation claim. The commenters contend that the definition in proposed §7.1602(6) would result in every actionable development in a workers’ compensation claim being considered a “claim.” According to the commenters, these actionable developments include every medical bill and income benefit, every attorney fee order, every decision and order of the DWC, and even billings submitted by the DWC to carriers for performing audits.

Agency Response: The Department disagrees and declines to make the recommended changes. The Department understands that the written notice of injury to a carrier under Labor Code §409.021(a) begins the process of payment of benefits under the Texas Workers’ Compensation Act. However, one of the purposes of the definition of “Claim” in §7.1602(6) is to make it absolutely clear that each demand for payment, service, or benefit under a plan to provide workers’ compensation benefits is considered a claim for purposes of these rules. The Department disagrees with the commenters for the following reasons. First, the term “Claim” is defined in §7.1602(6) to apply to adjusting or settling claims in connection with all types of insurance benefits contemplated under the Insurance Code §4151.001(1)--annuities, life benefits, health benefits, accident benefits, pharmacy benefits, and workers’ compensation benefits. Section 4151.001(1) provides in pertinent part that “Administrator" means a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. Thus, the definition is consistent with the Insurance Code §4151.001(1). Second, the definition of “Claim” in §7.1602(6) is necessary to clarify that a person adjusting or settling any of the individual components

involved in determining or paying workers' compensation benefits, including, but not limited to, a medical benefit, a temporary income benefit, a supplemental income benefit, a death benefit, a burial benefit, or the compensability of the injury, is within the ambit of the definition of "Administrator" in the Insurance Code §4151.001(1). While the filing of single written notice of injury triggers the process of payment of benefits under the Texas Workers' Compensation Act, the subsequent adjusting or settling functions can involve multiple and periodic demands for payment, service, or benefit, and multiple and periodic payments of medical benefits, income benefits, etc. As previously stated, the definition of "Claim" in §7.1602(6) makes it absolutely clear that each demand for payment, service, or benefit under a plan to provide workers' compensation benefits is considered a claim for purposes of these rules. Therefore, a person adjusting or settling any of the individual components involved in determining or paying workers' compensation benefits is regulated as an administrator under the rules, unless the person qualifies for an exemption under Chapter 4151, including §4151.002 or §4151.0021. Third, this concept is not unique to workers' compensation. Rather, it has been the Department's long-standing practice to apply this concept to other types of insurance, such as group health coverage, individual health coverage, or coverage provided by health maintenance organizations, for purposes of regulating administrators under the Insurance Code Chapter 4151. Fourth, the commenters' suggested revisions to the definition may conflict with the overall objective and intent of HB 472, which expanded the application of Chapter 4151 to persons performing or offering to perform administrative services in connection with workers' compensation benefits in this state. It is the Department's position that, at a minimum, an administrator subject to Chapter

4151 includes a person that has been delegated by an insurer, group, plan, or plan sponsor, the on-going management of or on-going discretionary decision-making authority to perform claim adjusting or settlement functions. Adoption of either of the commenters' suggestions, however, could result in a person that is delegated these types of functions after an injury is reported to a carrier under the Labor Code §409.021 being exempt from the rules. This could be the case even if that person made multiple and periodic payments for medical benefits, income benefits, etc. after the date the carrier receives the written notice of injury under §409.021. The Department's position is that such a result would conflict with the legislative intent and general objectives of HB 472 and the Insurance Code Chapter 4151.

§7.1602(8) and §7.1612. Fiduciary Bank Account

Comment: One commenter objects to the definition of "Fiduciary bank account" in proposed §7.1602(8) because the definition does not take into account the difference between premium funds and funds reserved for the payment of benefits and claims expenses. This commenter recommends that the proposed definition be revised to read: "An account used to hold premium collected by an administrator on behalf of an insurer or self-insured. This term does not include an account used to pay claims benefits and claims expenses." In a related comment, another commenter suggests that the Department include a new definition for "Claim payment account" such as "An account used to hold funds for the payment of benefits and claim expenses." Both commenters state that few if any workers' compensation administrators "ever touch a premium." Rather, workers' compensation administrators set up and control bank

accounts that are funded by a carrier or self-insured for the payment of claims. Another commenter recommends that proposed §7.1612 be modified to clarify that it does not apply to loss fund accounts. This commenter states that proposed §7.1612 applies to fiduciary bank accounts for premiums collected by administrators, and that some administrators do not collect premium but do hold loss fund accounts funded by the insurer to pay administered claims.

Agency Response: The Department does not agree that these changes are necessary at this time and declines to make the recommended changes. The term "Fiduciary bank account" is clearly defined in §7.1602(8), which is adopted without change, as "An account used to hold a premium." As observed by one commenter, proposed §7.1612 applies to fiduciary bank accounts for premiums collected by administrators. This definition is consistent with the Insurance Code §§4151.001(1) and 4151.105 – 4151.108 relating to an administrator's collection of premiums or contributions on behalf of an insurer, plan, or plan sponsor, or return premiums and return contributions (which function the same as return premiums but are administered by certain self-insurers) an administrator receives from an insurer, plan, or plan sponsor. Section 7.1612, in conjunction with the definitions of "Premium" and "Fiduciary bank account" in §7.1602(8) and (19), prescribes the general requirements related to the establishment and maintenance of fiduciary accounts used to hold premiums collected or received by administrators, including ensuring that all premiums are maintained by administrators in fiduciary accounts that are separate and distinguishable from any account used by an administrator to pay a claim on behalf of an insurer, HMO, plan sponsor, or group. Accordingly, §7.1612(i) prohibits an administrator from paying a

claim from a fiduciary bank account. This is consistent with the statutory prohibition in the Insurance Code §4151.109. Section 4151.109 provides that an administrator may not pay a claim from a fiduciary bank account established under §4151.107. Further, the Insurance Code §4151.108(3) lists the transfer to and deposit in a claims payment account for payment of a claim as provided by §4151.111 as one of seven purposes for which a withdrawal can be made from a fiduciary bank account holding premium. The Department understands that there is a difference between a fiduciary bank account used to hold premium and a “loss fund account," referred to as a "claims payment account" in the Insurance Code §4151.108. Regarding the comments that few if any workers’ compensation administrators “ever touch a premium," the Department is aware of administrators that do in fact administer workers’ compensation premiums, such as administrators that provide the day-to-day management of workers’ compensation self-insurance groups. If an administrator does not collect or receive premiums, the definition of the term “Fiduciary bank account” and rule provisions relating to fiduciary bank accounts do not apply. However, while not expressly required by these rules, the Department believes that it is a prudent business practice for insurers, HMOs, groups, plans, or plan sponsors to set up accounts for the payment of claims that include appropriate safe-guards and controls, such as those required in §7.1612 for establishing fiduciary bank accounts. It is also important that these safe-guards and controls otherwise comply with applicable state or federal laws, including, but not limited to, the Insurance Code §§4151.1042(a), 4151.105(a)(2) and (b), 4151.108(3), 4151.109, 4151.111, 4151.117, 4151.255, 4151.256, and 4151.257; and these rules, including §§7.1611(d) and (e), 7.1613(d), and 7.1616(a)(8). Sections 7.1611(d) and (e) and

7.1613(d) address the monitoring and oversight of administrators with regard to claims adjustment or claims settlement. Section 7.1611(d) and (e) prescribe the minimum information that an insurer should review during the required review or on-site audit. This includes a review of an administrator's compliance with the contract between the administrator and the insurer and the administrator's performance of claims adjudication and payment. Section 7.1613(d) requires a written agreement entered into under §7.1613 to include: (i) a requirement that an administrator comply with the requirements of the Insurance Code, the Labor Code, and rules adopted thereunder, including holding appropriate authorizations; (ii) a description of the administrative services the administrator is expected to provide and any applicable instructions related to the performance of those services, including references to an insurer's claims handling practices or procedures; (iii) a provision relating to the continuity of services and addressing the obligations of the administrator and the insurer under §7.1615 (relating to Transfer of Books and Records), including the method and manner in which the insurer and administrator will meet those requirements; and (iv) a provision addressing an insurer's obligation to review and audit the performance of its administrators under §7.1611 (relating to Operational Review and On-Site Audit), including the method and manner in which the insurer will meet those requirements. Further, §7.1616(a)(8) provides that an applicant or administrator that has engaged or is engaged in a pattern of failing to settle claims in accordance with contractual, regulatory, or statutory requirements may indicate that an applicant or administrator is operating or conducting business in a potentially hazardous or injurious manner.

§7.1602(17) and §7.1602(18). Definition of "Plan" and "Plan sponsor"

Comment: Three commenters object to the definition of "Plan" in proposed §7.1602(17), and one of these commenters also objects to the definition of "Plan sponsor" in proposed §7.1602(18). According to one commenter, the definition of "Plan" does not follow the definition of "Plan" in the Insurance Code §4151.001(4), and the Department does not have the authority to modify or amend the statutory definition of the term through rule-making; the commenter cites case law to support this assertion (*Cruse v. Texas Department of Transportation*, 2007 WL 1345433 (Tex. App. – Amarillo May 8, 2007, no pet.) and *Hollywood Calling v. Public Utility Commission*, 805 SW 2d 618 (Tex. App-1991)). This commenter recommends that the Department revise the definition of "Plan" in proposed §7.1602(17) to state: "As defined in the Insurance Code §4151.001(4)." According to a second commenter, the definition of "Plan" is too broad, and could include non-subscriber plans for workers' compensation and occupational accident coverage for independent contractors. This commenter requests an explicit exemption for non-subscriber plans from the definition of "Plan" in §7.1602(17). The third commenter states that the proposed definitions of "Plan" and "Plan sponsor" add the concept of funds and programs that provide workers' compensation benefits, although the Insurance Code §4151.001(4) does not mention workers' compensation. According to this commenter, the proposed definition of "Plan" greatly expands the statutory definition. Additionally, the commenter objects to the proposed definition of "Plan" because it adds "Pharmacy benefit" to the statutory definition of "Plan."

Agency Response: The Department disagrees and declines to adopt the commenters' suggested changes. For the following reasons, the Department disagrees that because

the definition of the term “Plan” in proposed §7.1602(17) is not exactly the same as the definition of the term “Plan” in the Insurance Code §4151.001(4), the term “Plan” in proposed §7.1602(17) is inconsistent with the statutory definition and the Department exceeded its rule-making authority. An analysis of the rule provisions in which the term “Plan” is used and the applicable case law supports the Department’s position. First, the term as defined in §7.1602(17) does not impose any additional burdens, conditions, or restrictions on a person beyond or inconsistent with the Insurance Code Chapter 4151. To the contrary, the definitions in proposed §7.1602(17) and (18), which are adopted without changes, are necessary to clarify that the term “Plan” for purposes of the rules may include a plan for pharmacy benefits or for workers’ compensation benefits. The addition of workers’ compensation benefits and pharmacy benefits to the definition of the term “Plan” in §7.1602(17) is consistent with the provisions and general objectives of the Insurance Code Chapter 4151. Section 4151.001(1) provides in pertinent part that “Administrator" means a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. Because §4151.001(1) explicitly provides for the regulation of administrators providing administrative services or functions in connection with pharmacy benefits or workers’ compensation benefits, it is necessary to define the term “Plan” to include these services or functions. Failure to clarify that the definition of “Plan” in §7.1602(17) includes “pharmacy benefits” and “workers’ compensation benefits” would create a conflict with §4151.001(1) and result in unnecessary ambiguity because of the inconsistency between the rules and §4151.001(1). This ambiguity

could result in compliance and enforcement difficulties. The definitions of “Plan” and “Plan Sponsor” in §7.1602(17) and (18) and use of the term “Plan sponsor” in the rules, including in §7.1612(b), (f)(2), and (g) and §7.1615(a), (d), and (e), are necessary to clarify and implement various provisions of the Insurance Code Chapter 4151, including §4151.103(d), which requires the Department to adopt rules to address the transfer of records from one administrator to another; and §§4151.106 – 4151.109, which address the fiduciary duties of administrators that collect premiums on behalf of an insurer, HMO, plan sponsor, or group. Therefore, the definition of “Plan” is in accordance with the legal principles that (i) rules promulgated by an administrative agency may not impose additional burdens, conditions, or restrictions beyond or inconsistent with the statutory provisions; and (ii) in making a determination as to whether a rule promulgated by an administrative agency exceeds the authority of the agency, the reviewing court must look not only to particular provisions but to all applicable provisions. (See *Hollywood Calling v. Public Utility Commission*, 805 S.W. 2d 618 (Tex. App--Austin, 1991 *no writ*)). Second, Chapter 4151 of the Insurance Code grants broad rulemaking authority to the Department. Section 4151.006 authorizes the Commissioner to adopt rules that are fair, reasonable, and appropriate to augment and implement this chapter, including rules establishing financial standards, reporting requirements, and required contract provisions. The term “Plan” is used in the rules to define the term “Claim” in §7.1602(6). The use of the terms “Plan” and “Claim” in the rules is authorized by and is consistent with the Department’s broad rulemaking authorization in the Insurance Code §4151.006. Thus, the particular statutory rulemaking provisions, which provide broad authorization to the Department to

promulgate rules, are a significant factor in determining whether the Department has exceeded its rulemaking authority. Third, not only are the rule provisions that define and use the terms “Plan” and “Plan sponsor” in harmony with, and not contrary to, the statutory provisions of the Insurance Code Chapter 4151, the use of these terms are also consistent with the general objectives of Chapter 4151, as amended by HB 472. According to the legislative bill analysis for HB 472, one of the main objectives is to include all workers’ compensation administrators into the regulatory framework of Chapter 4151 and under the regulatory purview of the Department. (Texas Senate State Affairs Committee, Bill Analysis (Committee Report, Amended), HB 472, 80th Legislature, Regular Session (May 15, 2007)). To ensure that all “Plans” and “Plan sponsors,” including those in connection with pharmacy benefits or workers’ compensation benefits as required under §4151.001(1) are appropriately regulated under Chapter 4151, it is necessary to include these types of plans in the definition of “Plan.” Administrative agencies generally possess by implication such powers as may be necessary to effectuate the legislative objectives which underlie the administrative powers expressly conferred upon them. (See *Hammack v. Public Utility Commission of Texas, 131 S.W. 3d 713, 723 (Tex. App.--Austin, 2004, no pet.))*

Additionally, the Department disagrees that the definition of “Plan” in §7.1602(17) is too broad because it could include non-subscriber plans for workers’ compensation and occupational accident coverage for independent contractors. Non-subscriber plans may be offered by employers that do not subscribe to the workers’ compensation system. In lieu of workers’ compensation insurance, these employers may offer their employees different types of insurance coverage or benefits that may include lines of

insurance subject to Chapter 4151 such as health, accident, and health benefits coverage. If a person acts or holds itself out as an administrator, as defined in §4151.001(1), for a non-subscriber plan that provides health, accident, health benefits, or any line of insurance subject to Chapter 4151 to residents in this state, the person is subject to the requirements of the Insurance Code Chapter 4151 and the rules, including the requirement to obtain an administrator certificate of authority, unless the persons meet an exemption under §4151.002 or §4151.0021. Additionally, an administrator administering a plan that is exempt from state regulation under the federal Employee Retirement Income Security Act (ERISA) for a non-subscriber that provides benefits for a work-related injury is not subject to the provisions of the Insurance Code Chapter 4151 or these rules for that plan. Accordingly, §7.1601(d) clarifies that the proposed new subchapter does not apply to a person acting as or holding itself out as an administrator for an ERISA qualified employee welfare benefit plan that is exempt from regulation by this state with respect to that particular employee welfare benefit plan.

§7.1602(19). Definition of “Premium”

Comment: Two commenters object to the definition of “Premium” in proposed §7.1602(19). One commenter states that the proposed definition of “Premium” includes the term “premium” itself to define the term and needs to be clarified to better describe what the term “Premium” means for purposes of the third-party administrator rules. This commenter recommends that the definition of the term “Premium” be revised to read: “Payments made to an insurance company to cover the cost of insurance for a certain

level of insurance coverage for a specified period of time. For purposes of the subtitle, the term may include contribution, return premium, and return contribution." According to the other commenter, the inclusion of the word "contributions" within the definition of "Premium" in proposed §7.1602(19) is unclear. This commenter states that although it can conceive of no possible way that funds used to pay claims could be considered "premium" funds, the final rule needs to contain a statement within the definition that "payments and funds used to pay claims are not within this definition of premiums."

Agency Response: The Department disagrees and declines to make the recommended changes to the definition of "Premium." The Department believes that the definition of "Premium" in proposed §7.1602(19), which is adopted without changes, is clear and complete for the following reasons. First, the term "Premium" is defined to include all of the types of funds that are collected on behalf of or received from an insurer, HMO, plan sponsor, or group. Such funds are collected for purposes related to insurance coverage and related benefits as contemplated under the Insurance Code 4151, including §4151.001(1) and §§4151.105 – 4151.108. As used in §7.1602(19) and the Insurance Code Chapter 4151, "Premium" and "contribution" refer to funds collected by an administrator on behalf of an insurer, HMO, plan sponsor, or group for insurance coverage providing annuities, health, accident, life, pharmacy, or workers' compensation benefits. As used in §7.1602(19) and the Insurance Code Chapter 4151, "return premium" and "return contribution" refer to funds received by an administrator from an insurer, HMO, plan sponsor, or group that are to be returned to an insured or plan participant under certain circumstances, e.g., upon the cancellation of a policy. Section 4151.001(1), relating to definition of "administrator," refers to "premiums and

contributions"; §4151.105, relating to payments to administrator, refers to a "premium" or "contribution" and a "return premium" or "contribution"; §4151.106, relating to certain funds collected or received by administrator, refers to "any premium or contribution" and "a return premium"; §4151.107, relating to delivery or deposit of certain funds received by the administrator, refers to "a premium, contribution, or return premium"; and §4151.108, relating to withdrawals from fiduciary bank accounts, refers to a "return premium." Second, although the term "return contributions" is not explicitly referenced in Chapter 4151, §4151.105(a) and §4151.107 contemplate an administrator receiving not only return premiums from an insurer, plan, or plan sponsor, but also the return of all or a portion of a contribution previously paid by an insured or plan participant. Thus, inclusion of the term "return contribution" in the definition of "Premium" is necessary to include all possible types of funds and to thereby clarify that a return payment of all or a portion of the contribution to an administrator for delivery to an insured or plan participant is a type of fund subject to the fiduciary bank account requirements specified in Chapter 4151 and these rules. Third, the definition of "Premium" in §7.1602(19), in conjunction with §7.1611, relating to operational review and on-site audit, is necessary to implement the fiduciary duty and fiduciary bank account requirements in the Insurance Code §§4151.106 – 4151.109. Section 4151.106 provides that an administrator holds a premium, contribution, or return premium in a fiduciary capacity. To implement this fiduciary requirement, §7.1612, relating to fiduciary bank accounts, requires an administrator to hold all premium, as defined in §7.1602(19), in a fiduciary capacity. Section 7.1612 prescribes the general requirements related to the establishment and maintenance of fiduciary accounts used to hold collected premiums,

as defined in §7.1602(19). Section 7.1612(g) requires an administrator to provide a copy of the records relating to the account activity of an insurer, HMO, plan sponsor, or group in a fiduciary bank account to the insurer, HMO, plan sponsor, or group, upon its reasonable request. The purpose of §7.1612(g) is to enable the insurer, HMO, plan sponsor, or group to properly oversee the activities of the administrator and to ensure that the premiums collected on its behalf are properly accounted for and maintained.

The Department also disagrees with the recommendation to include a statement in the definition of “Premium” to provide that "payments and funds used to pay claims are not within this definition of premiums." The Department believes that it is not necessary to add this language in order to specify the proper scope and applicability of the rules and believes that to do so, could result in unnecessary ambiguity. First, as previously stated, the rules in §§7.1601, 7.1611, and 7.1612 clearly and appropriately incorporate the terms “premium,” “contribution,” and “return premium,” as used in the Insurance Code Chapter 4151, including in the definition of the term “administrator” in §4151.001(1) and in §§4151.105 – 4151.108. For example, §7.1612 prescribes the general requirements related to the establishment and maintenance of fiduciary accounts used to hold premiums collected or received by administrators, including ensuring that all premiums are maintained by administrators in fiduciary accounts that are separate and distinguishable from any account used by an administrator to pay a claim on behalf of an insurer, HMO, plan sponsor, or group. Accordingly, §7.1612(i) prohibits an administrator from paying a claim from a fiduciary bank account; this is consistent with the statutory prohibition in the Insurance Code §4151.109. Furthermore, when read in context with the provisions of §§4151.105 – 4151.108 and §4151.111, the

terms “premium,” “contribution,” “return premium,” and “return contribution” as used in these rules are clearly distinguishable from funds deposited in a “claims payment account,” which are used for payment of a claim as provided by §4151.108(3) and §4151.111. The Insurance Code Chapter 4151 references the term “claims payment account” in §4151.108(3) and states in §4151.111(b) that “The administrator shall pay each claim on a draft authorized by the insurer, plan, or plan sponsor in the written agreement.” However, Chapter 4151 does not define the term “claims payment account” nor does it use the phrase suggested by the commenter, "payments and funds used to pay claims are not within this definition of premiums.” Second, prior to the enactment of HB 472 and in the context of life, health and annuities business, the Department has had experience distinguishing between a “fiduciary bank account” established to hold premium and a “claims payment account.” The Department has not encountered any problems or difficulties in making this distinction. The Department’s experience demonstrates that it is necessary to conduct a fact-specific, case-by-case analysis to determine (i) whether a particular account falls within the meaning of the statutory terms “fiduciary bank account” or “claims payment account for payment of a claim as provided by §4151.111” and (ii) whether particular funds fall within the meaning of the statutory terms “premium,” “contribution,” or “return premium.”

§7.1604(e). Application for Certificate of Authority: Other Information Required

Comment: One commenter objects to proposed §7.1604(e) as overly broad and giving the Commissioner unlimited authority to request any information deemed appropriate whether the information is or is not related to issues, facts, or circumstances germane to

whether or not an application for a certificate of authority should be approved. The commenter requests that the Department revise §7.1604(e) to require that any additional information deemed by the Commissioner to be required must be reasonably required in keeping with the standard established in HB 472 to adopt rules that are fair, reasonable and appropriate to augment and implement the Insurance Code Chapter 4151.

Agency Response: The Department disagrees and declines to make the commenter's suggested changes. Proposed §7.1604(e), which is adopted without change, states that "Pursuant to the Insurance Code §4151.052(a)(5), the commissioner may require the submission of any other information the commissioner reasonably requires in determining whether to approve or disapprove an application for a certificate of authority." As indicated in the rule provision, this requirement is consistent with the Insurance Code §4151.052(a)(5). Section 4151.052(a)(5) provides that the application for an administrator certificate of authority "must include the following: . . . any other information the commissioner reasonably requires." Therefore, §7.1604(e) is a statutory authorization that must be applied within the context of the authorizing statute. As such, §7.1604(e) is not overly broad and does not give the Commissioner "unlimited authority to request any information deemed appropriate whether the information is or is not related to issues, facts, or circumstances germane to whether or not an application for a certificate of authority should be approved." Also, because §7.1604(e) is a statutory authorization that must be applied within the context of the authorizing statute, it is in accordance with §4151.006 of the Insurance Code, which authorizes the Commissioner

to adopt rules that are fair, reasonable and appropriate to augment and implement the Insurance Code Chapter 4151.

§7.1607(b). Facts and Circumstances Affecting Issuance of Certificate of Authority: Notification of Material Change in Fact or Circumstance

Comment: One commenter contends that the requirement in proposed §7.1607(b) to notify the Department not later than the 30th day from the date an administrator or applicant becomes aware of any administrative action, order or judgment against the applicant or administrator is burdensome, unnecessary, and would require additional filings with the Department at odd time intervals. The commenter requests that proposed §7.1607(b) be modified to require that the administrator provide information to the Department pertaining to administrative actions, orders or judgments at the time of application or upon the annual renewal of the administrator's certificate of authority.

Agency Response: The Department disagrees and declines to make the change. First, the Department believes that the reporting of this information in a timely manner is necessary in order for the Department to monitor material changes in facts and circumstances that may affect the administrator’s continued compliance with the requirements of the Insurance Code Chapter 4151 and these rules. This monitoring is necessary to implement the Insurance Code §4151.052. Proposed §7.1607(a) and (b), which are adopted without change, are consistent with the Insurance Code §4151.052(a)(5), which provides that an application for a certificate of authority to engage in business as an administrator must include "any other information the commissioner reasonably requires.” Section 7.1607(b) is consistent with the Insurance

Code §4151.052(b), which provides that “An applicant for a certificate of authority or a certificate holder under” Chapter 4151 “shall notify the department of any other fact or circumstance affecting the applicant's or certificate holder's qualifications for a certificate of authority in this state as required by commissioner rule.” Section 7.1607(a) defines the phrase “material change in fact or circumstance” as any fact or circumstance that impacts the accuracy or completeness of the information filed in an applicant’s or administrator’s initial application for a certificate of authority under the Insurance Code Chapter 4151 and provides a non-exclusive list of material changes in fact or circumstances. These material changes in fact or circumstances include “any administrative action, order, or judgment issued against an applicant or administrator.” Section 7.1607(b) requires an administrator to notify the Department in writing of a material change in fact or circumstances not later than the 30th day from the date the administrator first becomes aware of the material change in fact or circumstance. The Department believes that the 30-day notification requirement in §7.1607(b) is reasonable, appropriate, and necessary because this kind of information, which includes any administrative action, order, or judgment issued against an applicant or administrator, may reflect negatively on the competence, fitness, or trustworthiness of the administrator or on the financial health of the administrator. If a reported change in fact or circumstance adversely reflects upon the integrity or financial health of the administrator, the Department must be able to take any necessary action as quickly as possible to prevent any injury to the public and insurance consumers of this state. Certainly, any administrative action, order, or judgment issued against an applicant or administrator is within the ambit of information that could adversely reflect upon the

integrity or financial health of the administrator and which could require quick action by the Department to prevent any injury to the public and insurance consumers of this state. Second, the Department is of the opinion that the commenter's suggested change that would require the administrator to provide information to the Department pertaining to administrative actions, orders or judgments upon the annual renewal of the administrator's certificate of authority is inconsistent with the Department's statutory obligation in the Insurance Code §4151.052(b) to monitor material changes in facts and circumstances that may affect the administrator's continued compliance with the requirements of the Insurance Code Chapter 4151 and these rules. Significantly, certificates of authority issued to administrators are not subject to annual renewal. However, even if the rule were changed to permit the annual filing of administrative actions, orders or judgments, such filing intervals could gravely reduce the effectiveness of the Department's monitoring which depends on prompt notice to the Department to enable the Department to take any immediate steps necessary to prevent any injury to the public and insurance consumers of this state. Third, §7.1607(a) and (b) replace existing §7.1612(a) and (c). Under existing §7.1612(c), an administrator is required to notify and deliver a copy of any order or judgment relating to certain specified actions to the Commissioner within 30 days of the occurrence. Based on the Department's experience in implementing existing §7.1612(c), the Department is not aware of any instances of the requirement being overly burdensome to those required to comply.

§7.1608. Fidelity Bonds

Comment: Two commenters object to proposed §7.1608, and one commenter requests clarification concerning the requirement for fidelity bonds. One commenter contends that requiring all entities that act as administrators to obtain fidelity bonds will be burdensome and serve no identifiable interest with respect to entities who do not handle funds on behalf of an administrator. This commenter recommends that the Department revise proposed §7.1608 to require a fidelity bond only from administrators who handle claim funds or premiums. The second commenter states that the requirement in proposed §7.1608(c) for an administrator or applicant to notify the Department not later than 10 days from the date the applicant or administrator first becomes aware of the fidelity bond cancellation or termination is too short. This commenter requests that the proposed 10-day notification be extended to 30 days. A third commenter requests confirmation that the required fidelity bonds are only required of administrators and not from other persons.

Agency Response: The Department declines to make the suggested changes. Proposed §7.1608, which is adopted without change, requires each administrator and each applicant for an administrator certificate of authority to obtain and maintain a fidelity bond that complies with the requirements of the Insurance Code §4151.055 and §7.1608. The fidelity bond requirements in §7.1608 are consistent with the Insurance Code §4151.055(a), which requires an applicant to obtain and maintain a fidelity bond and submit proof to the Commissioner that the applicant obtained the required fidelity bond as a precondition to the issuance of a certificate of authority to act as an administrator under the Insurance Code Chapter 4151. Section 4141.055(b) of the Insurance Code requires that the fidelity bond protect against an act of fraud or

dishonesty by the applicant or administrator in exercising the applicant's powers and duties as an administrator. Thus, to limit the applicability of §7.1608 to only administrators that handle claims funds or premiums is inconsistent with the fidelity bond requirements in the Insurance Code §4151.055. Additionally, such inconsistency between the statute and the rules creates unnecessary ambiguity which, in turn, could result in inconsistent compliance. Such inconsistent compliance could adversely effect the public and insurance consumers in Texas.

Concerning the request to reduce the notification requirement under §7.1608(c), the Department believes that 10 business days is an appropriate and reasonable amount of time under the limited circumstances in which a notification is required under §7.1608(c). Additionally, the 10-day notification requirement is necessary to implement the requirements in the Insurance Code §4151.055(a)(1) that an applicant or administrator obtain and maintain fidelity bond coverage that complies with §4151.055. An applicant or administrator is not required to comply with the 10-day notification requirement in §7.1608(c) when there is notice of cancellation or termination and the coverage is immediately replaced with sufficient new coverage. An applicant or administrator is only required to comply with the notification requirement in §7.1608(c) in circumstances in which there is cancellation or termination of the fidelity bond and coverage is not replaced with sufficient new coverage effective concurrently with the date of the cancellation or termination. Under these circumstances, an applicant or administrator is required under §7.1608(c) to immediately inform the Commissioner in writing that its fidelity bond was canceled or terminated and not replaced with new coverage effective concurrently upon the date of the cancellation or termination. The

notification cannot be later than 10 business days from the date the applicant or administrator first becomes aware of the cancellation or termination.

With regard to the commenter requesting clarification or confirmation that the required fidelity bonds are only required of administrators and not from other persons, under both Chapter 4151 and these rules, fidelity bonds are only required of those that meet the definition of “Administrator” in the Insurance Code §4151.001(1) and §7.1602(1), including administrator contractors and administrators subcontractors as defined in §7.1602(3) and (4) and each applicant for an administrator certificate of authority as required under §4151.055 of the Insurance Code.

§7.1609. Annual Report.

Comment: Two commenters object to proposed §7.1609 because it will require administrators that handle only piecemeal aspects of workers’ compensation claims to file annual reports. These commenters recommend that only administrators who handle funds or pay claims on behalf of a carrier or another administrator should be required to file an annual report with the Department. These commenters provide the following reasons to support their recommendations: (i) entities that handle only piecemeal aspects of workers' compensation claims will have little if anything to report, (ii) all necessary information can be obtained by way of reporting by the single entity that has overall management responsibility for an insurer, self-insured, or self-funded program, and (iii) without this change, the rules will result in duplication of data that will be difficult to analyze.

Agency Response: The Department disagrees and declines to make the suggested changes. The Insurance Code §4151.205 requires an administrator to annually file, not later than June 30, a report with the Commissioner on a form prescribed by the Commissioner, including a financial statement. Section 4151.205 requires that the report contain any information required by the Commissioner and that it be verified by at least two officers of the administrator. Proposed §7.1609, which is adopted without change, is consistent with the §4151.205 statutory requirements. To limit the applicability of §7.1609 to only certain administrators, as suggested by the commenters, is not consistent with the annual reporting requirements in §4151.205 of the Insurance Code and therefore, would exceed the Department's rulemaking authority. Further, the Department disagrees that any administrator will have "little if anything to report." The information required to be reported by an administrator under §7.1609 pertains to the administrator's activities and operations in Texas as well as the administrator's financial condition. This information is necessary for the Department to appropriately monitor an administrator's activities and operations, financial condition, and compliance with the provisions of the Insurance Code Chapter 4151 and these rules. Such monitoring is necessary to enable the Department to take any necessary action as quickly as possible in order to prevent any injury to the public and insurance consumers of this state. The Department further disagrees that all necessary information can be obtained through the reporting by the single entity that has overall management responsibility for an insurer, self-insured, or self-funded program. Because financial information is grouped and summarized for reporting purposes, it is the Department's opinion that the results, operations, performance, and business activities of individual parties may be

consolidated and embedded in such a manner as to make meaningful analysis problematic. Meaningful analysis is essential to ensure that the Department is able to properly monitor an administrator's activities and operations, financial condition, and compliance with the provisions of the Insurance Code Chapter 4151 and these rules. Finally, the Department disagrees that, without the recommended change, the resulting duplication of data will be difficult to analyze. To the contrary, the data reporting required by §7.1609 will result in an enhanced level of disclosure of an administrator's activities and operations and financial condition and will thereby, augment the ability of the Department to monitor compliance with Chapter 4151 and these rules. This too will assist the Department in taking appropriate regulatory action when needed to prevent any injury to the public and insurance consumers of this state.

§7.1611. Operational Review and On-Site Audit

Comment: Five commenters object to the semi-annual operational review requirements and on-site audit requirements of administrators in proposed §7.1611. According to one commenter, the semi-annual operational review and on-site audit requirements will result in many insurers being required to conduct operational reviews of multiple administrators at great expense and time, and such a requirement and the resulting costs and the costs associated with an on-site audit of an administrator is expected to significantly increase insurers' operational costs in a manner that is not reasonable nor anticipated by the Texas Legislature when it passed HB 472. This commenter recommends that the Department revise proposed §7.1611(a) to allow the semi-annual operational reviews be conducted electronically through the review of

claims data. According to a second commenter, the scope and burdens associated with the required semi-annual operational review and on-site audit requirements are staggering and out of proportion to any perceived benefit that could be gained by such audits and reviews. This commenter contends that the proposed audit requirements in themselves are unduly burdensome and unworkable, and asserts that for administrators with many customers and for insurers who frequently use administrators, the number of operational reviews and audits taking place for all these plans would be staggering. This commenter further argues that the scope of the required review and audit is overly broad. Specifically, the commenter contends that proposed §7.1611(d)(1)(A) is too broad and ambiguous because an insurance carrier is not in a position to judge whether a third party administrator is in compliance with the entirety of the Texas Insurance Code, the Texas Labor Code, and all applicable regulations, and a carrier has neither the resources nor the responsibility to assess all areas of an administrator's operations to determine whether the administrator is in compliance with all statutory and regulatory requirements of the Texas Labor Code and Insurance Code. This commenter also specifically objects to the on-site audit requirements because (i) they would be extremely burdensome and costly yet would provide no real benefits over an audit via electronic means; and (ii) for administrator subcontractors, they would be a practically impossible burden to satisfy, prohibitively expensive, and time-consuming. Additionally, this commenter argues that requiring all insurers and self-insurers who use administrators to engage in numerous, successive, overly broad on-site audits and operational reviews of administrators and subcontractors creates a highly inefficient, costly administration system that may lead to more employers opting out of workers'

compensation. This commenter recommends that (i) proposed §7.1611 be revised by deleting the proposed on-site audit requirements and allowing for audits via electronic means; (ii) proposed §7.1611 be modified to limit the scope of operational reviews and/or on-site audits to administrators only and not every subcontractor and to focus only on whether claims are being paid appropriately and on time; (iii) proposed §7.1611(d)(1)(A) be deleted, or alternatively, at a minimum, modified to clarify the specific regulations or statutes that a carrier is in position to assess the administrator's compliance; (iv) insurers be given discretion with respect to timing and scope of review and audit of documents and practices they deem appropriate; a more workable and practicable resolution would be that the insurers should provide for their right to audit in the written contract; and (v) in place of the overly broad mandatory audit and operational review system envisioned by proposed §7.1611, the Department be required to perform oversight of administrators as part of the Department's administrator certification and recertification process, including examinations to determine whether the administrators are paying benefits to injured workers in a timely and appropriate manner, and if not, then the Department should be required to engage in additional examinations of such entities and impose sanctions as warranted. According to a third commenter, the semi-annual operational review and on-site audit requirements in proposed §7.1611 are onerous and arbitrary. This commenter requests that the Department revise proposed §7.1611 to allow carriers discretion regarding oversight of the administrators with whom they contract, taking into account the level of risk, the cost/benefit associated with the type of services provided, and the strength of the underlying contract. A fourth commenter requests that the obligations of an insurer in

proposed §7.1611 be limited to inspection of an "administrator" and not also an administrator subcontractor, and requests that the phrase "by electronic means" be added to proposed §7.1611. A fifth commenter contends that for ancillary providers (administrator subcontractors), the semi-annual operational review and on-site audit requirements in proposed §7.1611 will add little value to the regulatory process, and will be very costly.

Agency Response: The Department disagrees and declines to make the requested changes. The Department disagrees that (i) the semi-annual operational review and on-site audit requirements in proposed §7.1611 are overly broad, unduly burdensome, unworkable, out of proportion to any perceived benefit, onerous, arbitrary, or will significantly increase insurers' operational costs in a manner that is not reasonable nor anticipated by the Texas Legislature when it passed HB 472; (ii) the on-site audit requirements are extremely burdensome and costly; (iii) the on-site audit requirements would be a practically impossible burden to satisfy, prohibitively expensive, and time-consuming for administrator subcontractors; and (iv) the semi-annual operational review and on-site audit requirements for administrator subcontractors will add little value to the regulatory process and will be very costly. Proposed §7.1611, which is adopted without change, is necessary to implement the requirements of the Insurance Code §4151.1042, which was enacted as part of HB 472. Section 4151.1042(c) provides that: "If an administrator administers benefits for more than 100 certificate holders, injured employees, plan participants, or policyholders on behalf of an insurer, **the insurer shall, at least semiannually, conduct a review of the operations of the administrator**. **At least biennially, the insurer shall conduct an on-site audit of the**

operations of the administrator." (emphasis added). Section 4151.1042(b) requires an insurer to ensure competent administration of its programs. Section 4151.1042(a) provides that if an insurer uses the services of an administrator, the insurer is responsible for determining the benefits, premium rates, reimbursement procedures, and claims payments procedures applicable to the coverage and for securing reinsurance, if any, and requires the insurer to provide each of its administrators with a copy of the written requirements applicable to these matters. Section 4151.1042(a) further requires that the responsibilities of the administrator as to any of these matters be set forth in the written agreement between the administrator and the insurer. As required by the Insurance Code §4151.1042(c) and §7.1611(a) and (b), the semi-annual review and biennial on-site audit requirements in §7.1611 apply only to an insurer, as defined in the Insurance Code §4151.001(2), that uses the services of an administrator that, in the aggregate, administers benefits in Texas on behalf of the insurer for more than 100 certificate holders, injured employees, plan participants, or policyholders. The operational review and audit of administrators by insurers required by the Insurance Code §4151.1042 and §7.1611 are significant because an insurer retains the ultimate responsibility and accountability for each function it delegates to an administrator. Thus, it is imperative that an insurer appropriately monitor the activities of each of its administrators to ensure their competent administration as contemplated by §4151.1042(b). This includes, but is not limited to, ensuring the administrator's compliance with the written agreement entered into between the insurer and the administrator and compliance with the applicable provisions of Insurance Code, the Labor Code, and rules adopted thereunder relating to their administration on behalf of

the insurer. In addition to the §7.1611(a) and (b) requirements, §7.1611(d) and (e) prescribe the minimum information that an insurer must review during the required review or on-site audit in order to ensure that each administrator is competently performing its administrative functions and services on behalf of the insurer in compliance with the provisions of the written agreement with the insurer and with applicable provisions of the Insurance Code, Labor Code, and rules adopted thereunder. Specifically, §7.1611(d)(1) requires that at a minimum, the operational review or on-site audit include evaluating (i) an administrator's compliance with applicable provisions of the Insurance Code, Labor Code, and rules adopted thereunder; (ii) compliance with the written agreement between the administrator and the insurer; (iii) the administrator's performance of claims adjudication and payment functions; (iv) the adequacy of the financial security maintained by the administrator, if any, such as the adequacy of security maintained for reimbursement of the amount paid by an insurance company that is payable from the deductible amounts of negotiated deductible workers' compensation policies under the Insurance Code §2053.203 and §8.4 of Title 28 of the Texas Administrative Code; and (v) the administrator's practices and procedures for establishing the adequacy of the insurer's reserves, if any. Section 7.1611(d)(2) also requires an insurer to develop a written summary of the objectives and scope of and a summary of the results of the review and on-site audit. Each summary must include a corrective action plan addressing any deficiencies found during the review or on-site audit. Section 7.1611(e) specifies that the purpose of the on-site audit is to verify the accuracy, integrity, and completeness of the information received during a review conducted by an insurer pursuant to §7.1611(a). Section 7.1611(e) also

requires that an on-site audit include: (i) a physical inspection of the administrator's place of business; and (ii) a written assessment of the reliability of the information provided to the insurer and relied upon by the insurer when conducting a review or on-site audit of the administrator. Review of the prescribed information through both reviews and on-site audits should enable an insurer to better assess its ability to meet its obligations under the Insurance Code, Labor Code, and rules adopted thereunder. Additionally, it is anticipated that an insurer's regular review of the required information will enable the insurer to foresee potential financial problems or solvency issues at a much earlier date, so that corrective action can be taken immediately.

Many, if not most, of the costs objected to by the commenters are the result of the Insurance Code §4151.1042 operational review and audit requirements, and not a result of these rules. These rules, however, include provisions that will reduce insurer's costs to implement the §4151.1042 requirements. For example, notwithstanding the §7.1611(a) and (b) operational review and audit requirements, §7.1611(c) permits an insurer to forego one review of an administrator in the same fiscal year in which the insurer audits the same administrator. As a result, §7.1611(c) will assist in reducing an insurer's review costs. Also, consistent with insurer responsibility and administrator oversight requirements in the Insurance Code §4151.1042, the requirements of §7.1611 impose a minimal level of oversight and responsibility on each insurer that utilizes the services of an administrator. This applies regardless of an administrator's contractual position, whether as a direct contractor or a downstream subcontractor. Further, §7.1611 does not dictate the precise methods, practices, systems, or procedures that must be utilized by an insurer during its review or audit of an administrator. Therefore,

each insurer has the flexibility to use the most economical means of compliance with the §7.1611 requirements. For example, some insurers may already have certain review or auditing procedures in place that meet all or the majority of the §7.1611 requirements. In addition, §7.1611 provides options for compliance with the various requirements. Therefore, insurers are able to select options that will result in less costs being expended, such as performing the semi-annual operational reviews through electronic means. Also, for example, §7.1611(a) permits an insurer to conduct a review of an administrator on its own premises or at another designated location. This allows an insurer to choose the most economical location for performing its review. Also, §7.1611(f) permits a review or on-site audit to be performed by an insurer or the insurer's designated representative. Because the proposed new requirements do not require an on-site audit to be conducted by an actuary or an independent CPA, an insurer may use its own employees to conduct an on-site audit. This also may result in costs savings. Finally, the probable costs of compliance with §7.1611 will vary substantially among insurers depending upon the following factors: (i) the number of administrators the insurer is required to review and audit; (ii) the size and complexity of the organization of each administrator the insurer is required to review and audit; (iii) the number of hours an insurer needs to review a particular administrator’s information; (iv) the adequacy of each administrator’s books and records; (v) whether an administrator’s internal controls are adequate; (vi) whether the insurer is already reviewing and auditing a particular administrator; (vii) whether the insurer is able to review the administrator through electronic means; and (viii) whether an insurer discovers substantial problems during a review or audit, including the depth and

complexity of those problems. Significantly, the §7.1611 review and auditing requirements are consistent with prudent business practices. Therefore, the Department does not anticipate that most insurers utilizing the services of an administrator will need to make significant changes to their current review and auditing methods, systems, practices, and procedures. Additionally, consistent with the Insurance Code §4151.1042(c), the operational review and audit requirements in §7.1611 would not apply to each and every subcontractor, but only to a subcontractor that is also an administrator, as defined in §7.1602(4), and only to an administrator subcontractor that administers benefits for more than 100 certificate holders, injured employees, plan participants, or policyholders on behalf of the insurer.

The Department disagrees with the objections to the requirements related to the semi-annual operational review and on-site audit requirements for administrator subcontractors for the following reasons. Section 7.1602(4) defines an “Administrator subcontractor” as: “An administrator as defined in the Insurance Code §4151.001(1) who contracts or enters into an agreement with an administrator contractor for the performance of all or a portion of the administrative services the administrator contractor previously agreed to perform on behalf of an insurer, HMO, plan sponsor, or group. The term does not include a person described by the Insurance Code §4151.002 or §4151.0021.” An insurer remains responsible for monitoring and overseeing the activities of all of its administrators, including its administrator contractors and administrator subcontractors. However, it may be appropriate for the administrator contractor that delegates the performance of a specific function to an administrator subcontractor to oversee the performance of that administrator subcontractor on the

insurer's behalf. Therefore, §7.1611(g) provides an insurer with the option of meeting the §7.1611 monitoring and oversight requirements for an administrator subcontractor by reviewing and auditing its administrator contractor only. However, an insurer may utilize this option *only if* two requirements are met. First, an administrator contractor must supply the insurer with all the necessary and relevant information relating to a particular administrator subcontractor. Second, the information provided to the insurer by the administrator contractor must indicate that no evidence of material non-compliance by the administrator subcontractor exists. If these two requirements are met, an insurer may utilize the option provided by §7.1611(g). This provision will result in fewer reviews and audits and will assist in reducing costs. Furthermore, none of the review or on-site audit requirements in §7.1611 impose any additional burdens, conditions, or restrictions on a person, including an administrator or insurer, beyond or inconsistent with the Insurance Code Chapter 4151.

The Department also disagrees that §7.1611(d)(1)(A) is overly broad or ambiguous because it requires an insurer to conduct reviews and on-site audits to determine whether a third party administrator is in compliance with the entirety of the Texas Insurance Code, the Texas Labor Code, and all applicable regulations. Section 7.1611(d)(1)(A) is necessary to implement §4151.1042(a) and (b) of the Insurance Code. As previously explained, §4151.1042(a) requires an insurer to ensure competent administration of its programs, and §4151.1042(b) provides that if an insurer uses the services of an administrator, the insurer is responsible for determining the benefits, premium rates, reimbursement procedures, and claims payments procedures applicable to the coverage. Section 7.1611(d)(1)(A) requires the insurer to conduct both a review

and an on-site audit as required under §4151.1042 and §7.1611(a) and (b) to assess the business practices and procedures of the administrator to ensure competent administration, including evaluating the administrator's compliance with the Insurance Code, the Labor Code, and any rules adopted thereunder, as applicable. Therefore, §7.1611(d)(1)(A) does not require an insurer to conduct reviews and on-site audits to determine whether a third party administrator is in compliance with the entirety of the Texas Insurance Code, the Texas Labor Code, and all applicable regulations. Rather, an insurer is required to conduct reviews and on-site audits to determine whether a third party administrator is in compliance with only those provisions of the Texas Insurance Code, Texas Labor Code, and regulations promulgated thereunder that are applicable to the administrative service being performed or offered to be performed by the administrator on behalf of the insurer.

Because of the statutory requirements in §4151.1042, the Department would exceed its rulemaking authority to adopt the commenter's recommendations to: (i) allow the semi-annual operational reviews to be conducted electronically through the review of claims data only; (ii) delete the proposed on-site audit requirements; (iii) limit the scope of operational reviews and/or audits to administrators only and not subcontractors and focus only on whether claims are being paid appropriately and on time; (iv) grant insurers with discretion with respect to timing and scope of review and audit of documents and practices they deem appropriate and provide that the insurers provide for their right to audit in the written contract; (v) allow insurers' discretion regarding oversight of the administrators with whom they contract, allowing them to take into account the level of risk, the cost/benefit associated with the type of services

provided, and the strength of the underlying contract; and (vi) require the Department to examine administrators, as part of its oversight of administrators' certification and recertification process, to determine whether the administrators are paying benefits to injured workers in a timely and appropriate manner, and if the Department determines that they are not, require the Department to conduct additional examinations of such entities and impose sanctions as warranted.

Comment: One commenter objects to the requirement in proposed §7.1611(d)(2) that insurers include a corrective action plan in the report of the operational review and on-site audit of the administrator due to an emerging trend of bad faith lawsuits being filed against workers' compensation insurers. This commenter requests that the Department delete proposed §7.1611(d)(2), which requires a corrective action plan when deficiencies are identified during a review or audit. The commenter further states that it does not object to insurers being required to develop a corrective action plan that could be requested by the Department should a need arise wherein Department staff would need to obtain a copy of an insurer's corrective action plan.

Agency Response: The Department declines to make the requested deletion of §7.1611(d)(2). Proposed §7.1611(d)(2), which is adopted without change, requires an insurer to develop a written summary of the objectives and scope of the review or on-site audit and a summary of the results of the review or on-site audit, which must include a corrective action plan addressing any deficiencies found during the review or on-site audit. The Department's response is based on the following reasons. First, the §7.1611(d)(2) requirement is necessary to implement the fundamental purpose of the Insurance Code §4151.1042, which is to require insurers to exercise appropriate

oversight over administrators to whom they have delegated the authority to perform statutorily required duties on behalf of the insurers in Texas. Second, §4151.1042(b) and (c) specifically require an insurer to ensure competent administration of its programs and to conduct periodic reviews and on-site audits of its administrators that, in the aggregate, administer benefits in Texas on behalf of the insurer for more than 100 certificate holders, injured employees, plan participants, or policyholders. Section 7.1611(d)(2) implements §4151.1042(b) and (c). For example, administrators are often delegated the responsibility to timely pay medical benefits and workers' compensation benefits on behalf of insurers, HMOs, plan sponsors, and groups. Many administrators have control over insurers' books and records and claims files. Because an insurer retains ultimate responsibility and accountability for the functions performed by its administrators, it is imperative that each insurer monitor the activities of its administrators, maintain appropriate oversight over its administrators, and take appropriate corrective action promptly to correct any deficiencies found by the insurer during a review or on-site audit or by other means. Therefore, §7.1611, including 7.1611(d)(2), is necessary to establish appropriate minimum insurer oversight requirements for its administrators. Appropriate minimum oversight includes requiring corrective action when deficiencies are uncovered during the course of a review or audit conducted under §7.1611 and §4151.1042(c). Third, the corrective action requirement in §7.1611(d)(2) is necessary to: (i) enable an insurer to better assess its ability to meet its obligations under the Insurance Code, Labor Code, and rules adopted thereunder; (ii) protect the interests of insurance consumers by ensuring that claims are handled appropriately and paid timely and that premium is collected, maintained and

dispersed properly, regardless of whether an insurer engages the services of an administrator or performs the required functions itself; and (iii) ensure an administrator's compliance with applicable statutes, rules, and contract provisions for the functions the administrator performs on behalf of the insurer. Fourth, it is anticipated that an insurer's regular review of the required information will enable the insurer to foresee potential financial problems or solvency issues at a much earlier date, so that appropriate corrective action can be taken immediately to prevent potential harm to Texas insurance consumers. Fifth, the Department anticipates that each insurer will establish performance goals for its administrators and review the performance of its administrators to determine if those goals are being met. The Department believes that this should result in financially healthier insurers, as well as more productive and efficient administrators that are in compliance with all applicable laws and rules. Sixth, the Department believes that deleting the corrective action requirement from §7.1611(d)(2) may result in situations in which necessary corrective action to rectify deficiencies is not fully or appropriately implemented by the administrator or compelled by the insurer. Such a result runs counter to the purpose of §4151.1042 that insurers must ensure competent administration of their programs, and may result in continuing or future noncompliance by administrators. This, in turn, could ultimately result in harm to Texas insurance consumers.

The commenter's stated preference that insurers be required to develop a corrective action plan that could be requested by the Department should a need arise is addressed in §7.1611(h), as proposed and adopted without changes. Section 7.1611(h) provides that a copy of the report, including any correction action plan required under

§7.1611(d)(2), be made available to the Department upon request. There is no requirement in the rules that the report, including any corrective action plan, must be automatically filed with the Department.

Comment: One commenter contends that §7.1611(a) and (b) establish an extremely low threshold of only 100 Texas-administered claims, certificate holders, policyholders or plan participants for triggering the type and frequency of operational reviews and on-site audits required by proposed §7.1611. This commenter argues that triggering such massive requirements based solely on an aggregate of 100 Texas claims, certificate holders, policyholders or plan participants seems unnecessary. This commenter suggests that the threshold be increased significantly and that it would appear to be more prudent that such review and on-site audit requirements, if they were to apply at all, apply only to those administrators with the most extensive operations in Texas.

Agency Response: The Department disagrees; additionally, the Department cannot make the requested change because to do so, would exceed the Department's rulemaking authority. The "more than 100 certificate holders, injured employees, plan participants, or policyholders" requirement is mandated in §4151.1042 of the Insurance Code. Therefore, to revise the rules in accordance with the commenter's recommendation to raise the threshold for required reviews and on-site audits would exceed the Department's rulemaking authority. Section 7.1611(a) and (b) reflect the thresholds contemplated in the Insurance Code §4151.1042(c) for determining when an insurer is required to conduct a review and an on-site audit of its administrators. The Insurance Code §4151.1042(c) provides that "If an administrator administers benefits for more than 100 certificate holders, injured employees, plan participants, or

policyholders on behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the administrator. At least biennially, the insurer shall conduct an on-site audit of the operations of the administrator." Section 7.1611(a) provides that "No less than two times each fiscal year, an insurer shall review the operations of each of its administrators that, in the aggregate, administers benefits in Texas on behalf of the insurer for more than 100 certificate holders, injured employees, plan participants, or policyholders." Section 7.1611(b) provides that "No less than once every two fiscal years, an insurer shall conduct an on-site audit of each of its administrators that, in the aggregate, administers benefits in Texas on behalf of the insurer for more than 100 certificate holders, injured employees, plan participants, or policyholders."

Comment: One commenter states that the semi-annual operational review requirements in proposed §7.1611(a) do not make sense since proposed §7.1607(a) and (c) require administrators to report any material change in fact or circumstances that impacts the accuracy or completeness of the information filed in an applicant's or administrator's initial application. The commenter suggests that the Department amend §7.1607(a) and (c) to require that an administrator provide the insurer with a copy of their notification to the Department of any material changes that must be reported pursuant to §7.1607.

Agency Response: The Department disagrees and declines to make the recommended revisions for the following reasons. First, §7.1607(a) and (c) and §7.1611(a) implement completely different requirements in the Insurance Code Chapter 4151. The operational review requirements in proposed §7.1611(a), which are adopted

without change, are necessary to implement the Insurance Code §4151.1042. Section 4151.1042 mandates the monitoring and oversight requirements of insurers over their administrators. Proposed §7.1607(a) and (c), which are also adopted without change, are necessary to implement the Insurance Code §4151.052(b). Section 4151.052(b) mandates certain reporting of administrators to the Department in accordance with rules adopted by the Commissioner. Except as provided by §7.1606(b), §7.1607(c) requires an applicant to continually update the information filed in its initial application for a certificate of authority. This includes notifying the Department in writing of a material change in fact or circumstance, while the application is pending with the Department, as required under §4151.052(b). This required notification is necessary to enable the Department to accurately assess an applicant's fitness for licensure. Further, if a reported change in the information filed in an applicant's initial application for a certificate of authority prevents an applicant from fulfilling the minimum requirements necessary for the Department to approve its application, the Department must be able to identify and assess those situations quickly and accurately. Second, the information an administrator is required to report to the Department under §7.1607(a) and (c) may involve confidential, proprietary, or commercially sensitive information from the perspective of the administrator. Third, to revise §7.1607(a) and (c) to require that an administrator provide the insurer with a copy of their notification to the Department of any material changes reported pursuant to §7.1607 would impose additional requirements on administrators that are not included in the proposed rules. Pursuant to Texas case law, this would be a substantive change to the proposed rules and would require re-publication of the proposal with an additional 30-day comment period.

§7.1613(d)(1). Written Agreements Between Administrators and Insurers

Comment: One commenter objects to proposed §7.1613(d)(1) because it contends that citing compliance with specific Texas state laws would be onerous and impracticable in agreements that address services provided in numerous jurisdictions on a national basis. The commenter recommends that the requirement that the written agreements contain references to several specific Texas statutes be deleted, or if not deleted, then the deadline for implementation of the written agreement provisions should be extended until at least June 1, 2010. According to the commenter, agreements between insurers and administrators often contain general provisions that the administrator shall comply with all applicable laws and regulations.

Agency Response: The Department agrees with the commenter's concern, but disagrees with the commenter's recommended changes to proposed §7.1613. Therefore, the Department has revised §7.1613(d)(1) as adopted to state that a written agreement entered into under §7.1613 "shall include a requirement that the administrator must comply with all statutory, contractual, and regulatory requirements related to a function assumed or carried out by the administrator and related to a plan for which the administrator performs or offers to perform administrative services." The Department believes that §7.1613(d)(1), as revised, will give insurers and administrators more flexibility in meeting the §7.1613(d)(1) requirement. The Department expects each administrator to comply with all applicable requirements of the Insurance Code and the Labor Code and rules adopted thereunder, including holding the appropriate licenses or certificates of authority under the Insurance Code or the Labor Code. The

language in §7.1613(d)(1), as revised, implements the Insurance Code §§4151.101 – 4151.103, 4151.253, 4151.257, concerning written agreements between administrators and insurers or plan sponsors.

§7.1614. Prohibited Acts

Comment: One commenter objects to proposed §7.1614 because it is not clear what inducements are considered improper under proposed §7.1614. The commenter describes certain payments to companies that receive as part of their compensation a percentage of the difference between the DWC's fee schedule amount and the ultimate amount paid to the health care provider (referred to as “PPO reductions”). The commenter states that these companies audit and make recommendations for payment or reduction of medical bills relating to workers' compensation claims. The commenter then states that this compensation might be considered an “improper inducement” under proposed §7.1614(a)(5), but that it is not clear from the wording. The commenter states that if the Department considers such payments or any other payments to be improper inducements, then it would be more clear to system participants if proposed §7.1614 was to reference Insurance Code §4151.117 as well as Labor Code §415.0036. The commenter states that perhaps that is what is intended by proposed §7.1614(b), but it is not clear.

Agency Response: The Department disagrees that proposed §7.1614, which is adopted without change, is unclear and declines to make the recommended change because it is not necessary. Section 7.1614(b) addresses the commenter’s concern. Section 7.1614(b) provides that an administrator may be subject to other prohibitions

under the Insurance Code, the Labor Code, and rules adopted thereunder that are not specified in §7.1614(a). Section 7.1614(b) includes the prohibition in the Insurance Code §4151.117(b). Section 4151.117(b) prohibits an insurer or plan sponsor from permitting or providing compensation or another thing of value to an administrator that is based on the savings accruing to the insurer or plan sponsor because of adverse determinations regarding claims for benefits, reductions of or limitations on benefits, or other analogous actions inconsistent with Chapter 4151, that are made or taken by the administrator.

§7.1615. Transfer of Books and Records

Comment: One commenter objects to the notification requirements in proposed §7.1615(d) and (e) because they would create an enormous administrative burden for administrators and the Department with no real benefit. The commenter also disagrees with the Department's estimated $60 cost of compliance with the 30-day notice requirements in proposed §7.1615(d) and (e) and argues that an administrator will not be able to pass this cost on to an insurer or to another administrator, as mentioned on pages 59 through 94 of the Department’s proposal published in the *Texas Register* on December 5, 2008. This commenter requests the notification requirements in proposed §7.1615(d) and (e) be deleted. The commenter states that there are literally thousands of such contractual relationships which change on a frequent basis, and that if the proposed rule is left unchanged, the Department may be inundated with hundreds of such notices assuming that administrators are able to track all the contractual changes that take place.

Agency Response: The Department declines to make the requested deletion of the notification changes. The Department disagrees that the notification requirements in proposed §7.1615(d) and (e), which are adopted without changes, will be an administrative burden on an administrator or the Department. The Department also disagrees that §7.1615(d) and (e) provide no real benefit. Section 7.1615(d) and (e) are necessary to implement the Insurance Code §4151.103(d), which requires the Commissioner to adopt rules to address the transfer of records from one administrator to another. Section 7.1615(d) and (e) also are consistent with the statutory provisions in the Insurance Code §§4151.112 (Maintenance of Books and Records), 4151.113 (Access to Books and Records), and 4151.114 (Disposition of Books and Records or Termination of Agreement). Section 7.1615(d) and (e) do not, as the commenter contends, require administrators to notify the Department of every change to a written agreement between administrators or between administrators and insurers, HMOs, plan sponsors, or groups. Rather, §7.1615(d) and (e) require a written notice to the Department only in situations in which a relationship or written agreement is terminated. The Department anticipates that this requirement will mitigate the problems that the Department has experienced concerning the termination of agreements between administrators or between administrators and insurers, HMOs, plan sponsors, or groups, including instances involving the disruption of claim payments during the transition when books and records are transferred to a new carrier or administrator. The notification requirements in §7.1615(d) and (e) provide the Department with the opportunity to monitor specific transition periods to ensure that claims are timely paid, premiums are appropriately collected and transferred, and the financial condition of

insurers, HMOs, plan sponsors, groups, and administrators remain stable. Finally, administrators have been required since 1989 to send a similar written notice to the Department under the Insurance Code §4151.114 (formerly Article 21.07-6 §14(g). Based on the Department's experience in implementing §4151.114 (formerly Article 21.07-6 §14(g)), the Department is not aware of any instances of the notice requirement creating an enormous administrative burden for administrators or the Department. Although this notice requirement has existed for many years, the Department in recent years has experienced some problems including instances involving the disruption of claim payments. As a result of these problems, the proposal reiterates the §4151.114 statutory requirement in §7.1615(d) and (e). The Department believes that this may reduce future non-compliance with §4151.114 and thereby, reduce future disruptions in claim payments.

The Department also disagrees that the Department's cost estimate was understated. Because the commenter inaccurately read proposed §7.1615 to require notice to the Department of the "literally thousands of such contractual relationships which change on a frequent basis," it is understandable that the commenter would think that the cost note for the notice requirement was understated. As previously explained, §7.1615(d) and (e) do not require administrators to notify the Department of every change to a written agreement between administrators or between administrators and insurers, HMOs, plan sponsors, or groups. Rather, §7.1615(d) and (e) require a written notice to the Department only in situations in which a relationship or written agreement is terminated. Therefore, the Department believes that it provided an accurate estimation of the probable associated costs of compliance with the §7.1615 notification

requirements. In the Public Benefits/Cost Note section of the Department's proposal, the Department stated that it anticipates that the total probable costs for complying with the §7.1615 notification requirements will be less than $60. This estimation is based upon (i) a member of an administrator's administrative staff preparing the necessary information in less than one hour, at an estimated mean salary rate of $14.13 per hour; and (ii) a member of an administrator's management staff reviewing and approving the prepared information in less than one hour, at an estimated mean salary rate of $44.87 per hour. The Department expects the notice typically to take the form of a simple letter that, depending on the circumstances, may require only a few sentences to comply with the §7.1615(d) and (e) requirements. Additionally, based upon the experience of the Department, the Department believes that administrators generally charge their clients amounts that are typically designed to be sufficient to cover the administrative expenses incurred by those administrators. Section 7.1615(c) provides each administrator with the flexibility to negotiate the most economical means of complying with the §7.1615 requirements.

§7.1616. Hazardous or Injurious Operating Conditions

Comment: Three commenters object to proposed §7.1616 as overly broad, overreaching, open-ended, or unclear. The reasons provided to support their objections are that proposed §7.1616: (i) is not specific enough about what may constitute "any unlawful activity" by management staff as referenced in proposed §7.1616(a)(6); (ii) is not specific enough about what may constitute "hazardous or injurious manner" as referenced in proposed §7.1616(b); (iii) includes circumstances under which an

applicant or administrator may be considered by the Department to be operating or conducting business in a hazardous or injurious manner that exceed the list of grounds for which the Department may deny, suspend or revoke a certificate of authority under the Insurance Code §4151.301; (iv) does not specify the basis for determining that an applicant or administrator is operating in a hazardous or injurious manner; the commenter cites the Texas Constitution, Article I, Sections 13 and 19 and case law for support; and (v) leaves a large loophole to allow the Department to identify virtually any practice as “hazardous.” One commenter states that while it appreciates that the Department cannot define in regulation each and every possible hazardous or injurious condition, it recommends revising proposed §7.1616(b) to state "other activities similar in nature and effect to the activities identified in subsection (a)." This commenter states that this revision will provide clearer guidance to the industry. A second commenter suggests that proposed §7.1616 be revised to be more specific, perhaps by cross-referencing the laundry list of improper acts contained in the Insurance Code §4151.301. A third commenter recommends that the Department revise proposed §7.1616 to reflect that an applicant or administrator may be considered by the Department to be operating or conducting business in a hazardous or injurious manner if the Department determines that grounds exist for denial, suspension, or revocation of a certificate of authority identified in the Insurance Code §4151.301. This commenter recommends the deletion of proposed §7.1616(b). The commenter contends that the Texas Constitution, Article I, Sections 13 and 19 guarantees due process; the commenter cites to various court decisions for support. The commenter states that individuals must be afforded both substantive and procedural due process. (*Texas*

Workers' Comp. Comm'n v. Patient Advocates, 136 S.W.3d 643, 658 (Tex. 2004)). Substantive due process protects against the arbitrary and oppressive exercise of government power, regardless of the fairness of the procedures. *Daniels v. Williams*, 474 U.S. 327, 331, 88 L. Ed. 2d 662, 106 S. Ct. 662 (1986). A statute which forbids or requires the doing of an act in terms so vague that men and women of common intelligence must necessarily guess at its meaning and differ as to its application violates the first essential protection of due process of law. *Baker v. State*, 50 S.W.3d 143, 145 (Tex. App. – Eastland 2001, pet. ref'd) *citing Connally v. General Const. Co.*, 269 U.S. 385, 46 S. Ct. 126, 70 L. Ed. 322 (1926). A statute is void for vagueness if it "fails to give a person of ordinary intelligence fair notice that his contemplated conduct is forbidden by the statute." *Baker v. State*, 50 S.W.3d at 145; *citing Papachristou v. City of Jacksonville*, 405 U.S. 156, 92 S. Ct. 839, 31 L. Ed. 2d 110 (1972).

Agency Response: The Department declines to make the recommended changes for the following reasons. The Department disagrees that proposed §7.1616(b) should be revised to state "other activities similar in nature and effect to the activities identified in subsection (a)." Section 7.1616(a) specifies eight illustrative examples of conduct that may indicate that an applicant or administrator is operating or conducting business in a potentially hazardous or injurious manner. However, §7.1616(a) does not provide an exhaustive list of all possible factors or conditions relating to the financial condition or business operations or conduct of an applicant or administrator that may indicate that an applicant or administrator is operating or conducting business in a potentially hazardous or injurious condition. This is because the Department cannot define in a regulation each and every possible hazardous or injurious condition. Accordingly, the

Department does not believe that it would be appropriate or sufficient from a regulatory or public policy perspective to limit §7.1616(b) to only those activities that are similar in nature and effect to the few illustrative examples reflected in §7.1616(a).

The Department also disagrees that proposed §7.1616 should be revised to reflect that an applicant or administrator may be considered by the Department to be operating or conducting business in a hazardous or injurious manner if the Department determines that grounds exist for the denial, suspension, or revocation of a certificate of authority identified in the Insurance Code §4151.301 and that §7.1616(b) should be deleted. A fundamental objective of §7.1616 is to provide regulatory guidance to the industry on one particular provision of §4151.301 of the Insurance Code, specifically §4151.301(8). Section 4151.301 specifies that the Department may deny an application for a certificate of authority or discipline the holder of a certificate of authority under Subchapter G of Chapter 4151 of the Insurance Code if the Department determines that the applicant or holder, individually, or through an officer, director, or shareholder meets one of 14 statutorily specified criteria. Section 4151.301(8), which is one of the 14 statutorily specified criteria, relates to administrators whose financial condition, operations or conduct, may render further transactions in this state hazardous or injurious to insured persons or the public. By providing applicants and administrators with guidance through illustrative examples of situations that may reflect potentially hazardous or injurious operating conditions, the Department anticipates that applicants and administrators will take preventative steps to avoid these types of situations. This should result in financially healthier applicants and administrators. Thus, the Department declines to make the suggested change, in part, because the change would

negate the public policy benefits of providing regulatory guidance regarding compliance with the Insurance Code §4151.301(8). However, as a result of the comments, the Department has revised §7.1616(b) as adopted for purposes of clarity. The Department believes that this clarification addresses the commenters' concerns, including the assertion that the proposed §7.1616(b) has a loophole to allow the Department to identify virtually any practice as "hazardous. Section 7.1616(b) as adopted provides that "Other facts and circumstances not specified in §7.1616(a), as determined by the commissioner, that relate to the financial condition or business operations or conduct of an applicant or administrator in this state may also indicate that an applicant or administrator is operating in a hazardous or injurious manner." This clarification does not materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

Additionally, the Department is of the opinion that the provisions of §7.1616, as adopted, including §7.1616(b), are not overly broad, overreaching, open-ended, vague, confusing, or unclear. Section 7.1616 is authorized by the Insurance Code §4151.006 and §4151.301(8). Section 4151.006 authorizes the Commissioner to adopt rules relating to financial standards for administrators. Section 4151.301(8) authorizes the Department to deny an applicant's application for a certificate of authority, or suspend or revoke an administrator's certificate of authority, if the Department determines that an administrator or applicant is in a financial condition, or is operating or conducting business in a manner, that would render further transaction of business in this state hazardous or injurious to insured persons or the public. Section 7.1616(a) specifies in a clear manner illustrative examples of conditions that may indicate when an administrator

or applicant is operating or conducting business in a way that would render further transaction of business in this state hazardous or injurious to insured persons or the public. These examples include: (i) failure to file financial statements, documents, records, or reports required under the Insurance Code Chapter 4151 or these rules within the time periods prescribed by the Insurance Code Chapter 4151, these rules, or as requested by the Department pursuant to law; (ii) the filing of any false or misleading financial information; (iii) inability of the applicant or administrator to pay its obligations as they become due and payable; (iv) failure to maintain records sufficient to permit examiners to determine its financial condition or compliance with the Insurance Code, the Labor Code, and rules adopted thereunder; (v) failure to employ management staff with the experience, competence, or trustworthiness to conduct its operations in a safe or sound manner; (vi) the employment of management staff that has engaged in any unlawful activity; (vii) failure to comply in the past or in the present with the terms of a written agreement with an insurer, HMO, plan sponsor, or group; (viii) engaging in the past or engaging in the present in a pattern of failing to settle claims in accordance with contractual, regulatory, or statutory requirements; or (ix) engaging in the past or engaging in the present in fraudulent or dishonest practices or acts. As previously explained, §7.1616(a), however, does not provide an exhaustive list of all possible factors and circumstances that the Department or Commissioner may consider when determining whether an administrator or applicant is operating or conducting business in a manner contemplated by the Insurance Code §4151.301(8). Therefore, §7.1616(b), as adopted, clarifies that in determining whether an administrator or applicant is operating or conducting business in a potentially hazardous or injurious manner, the

Commissioner may consider other factors, as determined by the Commissioner, that relate to the financial condition or business operations or conduct of an applicant or administrator in this state to determine whether an applicant or administrator is operating in a hazardous or injurious manner. Any of the specified factors in §7.1616(a) and any of the factors determined by the Commissioner pursuant to §7.1616(b) may be a basis for the Commissioner to initiate regulatory action against an administrator or applicant under the Insurance Code. However, the existence of one or more of the factors or conditions does not necessarily mean that an administrator or applicant is operating or conducting business in a manner that would render further transaction of business in this state hazardous or injurious to insured persons or the public. In evaluating any of these factors or conditions, all circumstances concerning the administrator's or applicant's condition, activities, and operations must be evaluated in order to determine whether an administrator or applicant is operating or conducting business in a potentially hazardous or injurious manner. Section 7.1616, including §7.1616(b), is necessary to ensure that corrective actions can be taken at the earliest possible point in time to alleviate or prevent harm to the public and insurance consumers of this state as a result of an administrator's hazardous or injurious operating condition. The §7.1616 provisions are substantially similar to the Department's hazardous financial condition rules in §8.3 and §8.4 of Title 28 of the Texas Administrative Code. Section 8.3 rules relate to hazardous conditions of insurers, and §8.4 rules relate to hazardous conditions concerning negotiated deductible workers' compensation policies. It is the Department's experience in implementing §8.3 since 1989 and §8.4 since 2005 that such rules have worked well in

practice to indicate certain conditions that may possibly indicate potentially hazardous conditions, while giving the Commissioner discretion to decide whether or not regulatory action is needed and the type of regulatory action to take, based on a case-by-case, fact-specific determination relating to a specific insurer. The Department's experience in implementing §8.3 and §8.4 has been that (i) the provisions have specified the basis for determining that an applicant or administrator is operating in a hazardous or injurious manner; (ii) the provisions have been specific enough about what may constitute "hazardous or injurious manner" as referenced in proposed §7.1616(b); (iii) no individual or entity has been deprived of substantive or procedural due process as a result of the rules; (iv) no individual or entity has encountered requirements so vague that men and women of common intelligence were forced to guess at their meaning; and (v) the rules have given persons of ordinary intelligence fair notice of the type of conduct that is forbidden by the statute. The Department anticipates that §7.1616 will be similarly effective and give the Commissioner the discretion needed to determine whether or not a hazardous or injurious condition exists based upon case-by-case, fact-specific determinations relating to a specific administrator. For these reasons, the Department disagrees that §7.1616 as adopted deprives any individuals of substantive or procedural due process, as contemplated in *Texas Workers' Comp. Comm'n v. Patient Advocates*, 136 S.W.3d 643, 658 (Tex. 2004) and *Daniels v. Williams*, 474 U.S. 327, 331, 88 L. Ed. 2d 662, 106 S. Ct. 662 (1986). The Department disagrees that §7.1616 as adopted forbids or requires the doing of an act in terms so vague that men and women of common intelligence must necessarily guess at its meaning and differ as to its application as contemplated in *Baker v. State*, 50 S.W.3d 143, 145 (Tex. App. –

Eastland 2001, pet. ref'd) *citing Connally v. General Const. Co.*, 269 U.S. 385, 46 S. Ct. 126, 70 L. Ed. 322 (1926). The Department disagrees that §7.1616 as adopted fails to give a person of ordinary intelligence fair notice that his contemplated conduct is forbidden by the statute as contemplated in *Baker v. State*, 50 S.W.3d at 145; *citing Papachristou v. City of Jacksonville*, 405 U.S. 156, 92 S. Ct. 839, 31 L. Ed. 2d 110 (1972).

The Department disagrees with the comment that §7.1616(a)(6) is unclear because it does not state what may constitute "any unlawful activity" by management staff. It means exactly what it says. "Any unlawful activity" is any activity that violates any law.

§7.1617. Examinations

Comment: One commenter recommends that the Department amend proposed §7.1617(b) to require the Department to provide at least three days' notice of an inspection in order to facilitate the orderly production of claim files for audit purposes without disrupting the claims payment function, which may result in penalties for claims that are paid late during the course of the audit.

Agency Response: The Department declines to make the change. The current language is consistent with the Insurance Code §4151.202(c). Section 4151.202(c) requires the Commissioner to give notice to the administrator of the examiner's intent to conduct an on-site examination before an examiner enters an administrator's property. The notice must be (i) in the form required by rule adopted by the Commissioner and (ii) include the date and estimated time that the examiner will enter the administrator's

property. In accordance with current Department practice, the Department anticipates that an approximately two weeks' prior notice will be provided of an examination. However the Department reserves the right to conduct a more expeditious examination should circumstances warrant; in such instances, notice will be provided in accordance with the Insurance Code §4151.202(c)

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

For: Office of Public Insurance Counsel.

Against: None.

For, with changes: Insurance Council of Texas.

Neither for nor against, with changes: Parker & Associates, L.L.C.; American Insurance Association; American Association of Independent Claims Professionals; Texas Mutual Insurance Company; and CompPharma.

6. STATUTORY AUTHORITY. The new sections are adopted under the Insurance Code, the Labor Code, and the Education Code.

The Insurance Code Chapter 1272 regulates the delegation of certain functions by health maintenance organizations. The Insurance Code §1272.058 provides that a delegation agreement required by the Insurance Code §1272.052 must require the delegated entity to provide the license number of a delegated third party performing a function that requires a license as a third-party administrator under the Insurance Code Chapter 4151 or utilization review agent under Article 21.58A or another license under this code or another insurance law of this state.

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

The Insurance Code Chapter 4151 regulates administrators. The Insurance Code §4151.001 defines the terms that are used in Chapter 4151, including the terms administrator, insurer, person, plan, and plan sponsor. The Insurance Code §4151.002 and §4151.0021 provide exemptions from the requirements of the Insurance Code Chapter 4151 for certain persons meeting specified conditions. The Insurance Code §4151.004 provides that an insurer or health maintenance organization that is not exempt under §4151.002(3) or (4) is subject to all provisions of the Insurance Code Chapter 4151 other than the Insurance Code §§4151.005, 4151.051 - 4151.054, 4151.056, and 4151.206(a)(1). The Insurance Code §4151.006 provides that the Commissioner may adopt rules that are fair, reasonable, and appropriate to augment and implement the Insurance Code Chapter 4151, including rules establishing financial standards, reporting requirements, and required contract provisions. The Insurance Code §4151.051(a) provides that an individual, corporation, organization, trust, partnership, or other legal entity may not act as or hold itself out as an administrator unless the entity is covered by and is engaging in business under a certificate of authority issued under the Insurance Code Chapter 4151. The Insurance Code §4151.052(a) provides that an application for a certificate of authority to engage in business as an administrator must be in a form prescribed by the Commissioner.

Additionally, the Insurance Code §4151.052(a) specifies the items that must be included in an application for a certificate of authority, including basic organizational documents of the applicant; a description of the applicant and the applicant's services, facilities, and personnel; an audited financial statement of the applicant covering the preceding three calendar years or any lesser period that the applicant and any predecessors of the applicant have been in existence; and any other information the Commissioner reasonably requires. The Insurance Code §4151.052(b) requires an applicant for a certificate of authority or a certificate holder under the Insurance Code Chapter 4151 to notify the Department in the manner prescribed by Commissioner rule of a change of control in the applicant's or certificate holder's ownership not later than the 30th day after the effective date of the change. Additionally, the Insurance Code §4151.052(b) requires an applicant for a certificate of authority or a certificate holder under the Insurance Code Chapter 4151 to notify the Department of any other fact or circumstance affecting the applicant's or certificate holder's qualifications for a certificate of authority in this state as required by Commissioner rule. The Insurance Code §4151.053 provides that the Commissioner shall approve an application for a certificate of authority to engage in business in this state as an administrator if the Commissioner is satisfied that granting the application would not violate a federal or state law; the financial condition of the applicant or of each person who would operate or control the applicant is such that granting a certificate of authority would not be adverse to the public interest; the applicant has not attempted to obtain the certificate of authority through fraud or bad faith; the applicant has complied with the Insurance Code Chapter 4151 and rules adopted by the Commissioner under the Insurance Code Chapter 4151;

and the name under which the applicant will engage in business in this state is not so similar to that of another administrator or insurer that it is likely to mislead the public. Before the Commissioner issues an applicant a certificate of authority, the Insurance Code §4151.055(a) requires an applicant to obtain and maintain a fidelity bond that complies with the Insurance Code §4151.055 and to submit to the Commissioner proof that the applicant has obtained the fidelity bond. The Insurance Code §4151.101(a) provides that an administrator may provide services only under a written agreement with an insurer or plan sponsor. The Insurance Code §4151.101(b) provides that the Commissioner by rule may prescribe provisions that must be included in the written agreement. The Insurance Code §4151.102(a) provides that the written agreement must include each requirement prescribed by the Insurance Code Chapter 4151, Subchapter C, except for a requirement that does not apply to any function the administrator performs. The Insurance Code §4151.102(a-1) provides that the written agreement must include a statement of the duties that the administrator is expected to perform on behalf of the insurer, and the lines, classes, or types of insurance that the administrator is authorized to administer. Additionally, under the Insurance Code §4151.102(a-1), the agreement must include, as applicable, provisions regarding claims handling and other standards relating to the business underwritten by the insurer. The Insurance Code §4151.103(a) requires an administrator and the insurer, plan, or plan sponsor to retain a copy of the written agreement as part of their official records during the term of the agreement and until the fifth anniversary of the date on which the agreement expires. The Insurance Code §4151.103(d) provides that the Commissioner shall adopt rules to address the transfer of records from one administrator to another.

The Insurance Code §4151.1042(a) provides that if an insurer uses the services of an administrator, the insurer is responsible for determining the benefits, premium rates, reimbursement procedures, and claims payment procedures applicable to the coverage and for securing reinsurance, if any. Further, under the Insurance Code §4151.1042(a), an insurer is required to provide a copy of the written requirements relating to those matters to the administrator. Additionally, the responsibilities of the administrator as to any of those matters must be set forth in the written agreement between the administrator and the insurer. The Insurance Code §4151.1042(b) provides that an insurer shall ensure competent administration of its programs. The Insurance Code §4151.1042(c) provides that if an administrator administers benefits for more than 100 certificate holders, injured employees, plan participants, or policyholders on behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the administrator. Additionally, under the Insurance Code §4151.1042(c), an insurer is required to conduct an on-site audit of the operations of the administrator at least biennially. The Insurance Code §4151.105(a) provides that if an insurer, plan, or plan sponsor uses the services of an administrator, a payment of a premium or contribution to the administrator by or on behalf of an insured or plan participant is considered to have been received by the insurer, plan, or plan sponsor, and a payment of a return premium, contribution, or claim to the administrator by the insurer, plan, or plan sponsor is not considered payment to the insured, plan participant, or claimant until the insured, plan participant, or claimant receives the payment. The Insurance Code §4151.105(b) provides that the Insurance Code §4151.105 does not limit a right of an insurer, plan, or plan sponsor against the administrator resulting from the administrator's failure to make

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

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

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

by and the financial condition of the administrator. The Insurance Code §4151.201(c) provides that before an examiner enters an administrator's property, the Commissioner shall give notice to the administrator of the examiner's intent to conduct an on-site evaluation. Further, under the Insurance Code §4151.201(c), the notice must be in the form required by rule adopted by the Commissioner and include the date and estimated time that the examiner will enter the administrator's property. The Insurance Code §4151.201(d) provides that an examiner shall comply with operational rules of an administrator while on the administrator's property. The Insurance Code §4151.202(a) provides that an examination under the Insurance Code §4151.201 must include a review of each existing written agreement between the administrator and an insurer or plan sponsor and the administrator's financial statements. The Insurance Code §4151.203 provides that the cost of an examination under the Insurance Code §4151.201 shall be paid from the fee collected under the Insurance Code §4151.206(a)(2) and with revenue from the maintenance tax levied under the Insurance Code Chapter 259. The Insurance Code §4151.205(a) requires an administrator, not later than June 30, to annually file with the Commissioner a report on a form prescribed by the Commissioner. Further, under the Insurance Code §4151.205(a), the report must contain any information required by the Commissioner and must be verified by at least two officers of the administrator. The Insurance Code §4151.205(b) requires the annual report to cover the preceding calendar year. Except as provided by the Insurance Code §4151.205(f), the Insurance Code §4151.205(c) requires the annual report to include an audited financial statement performed by an independent certified public accountant. Further, under the Insurance Code §4151.205(c), an audited

financial statement prepared on a consolidated basis must include a columnar consolidating or combining worksheet that shall be filed with the annual report. Additionally, the amounts shown on the consolidated audited financial report must be shown on the worksheet, the amounts for each entity must be stated separately, and explanations of consolidating and eliminating entries must be included. The Insurance Code §4151.205(d) requires the annual report to include notes to the financial statement or attachments that reflect the complete name and address of each insurer in this state with which the administrator had an agreement during the preceding fiscal year. The Insurance Code §4151.205(e) provides that information derived from an audited financial statement contained in an annual report under the Insurance Code §4151.205 is confidential and is not subject to disclosure under the Government Code Chapter 552. The Insurance Code §4151.205(f) provides that an administrator who receives less than $10 million annually as compensation for performing administrative services and operates under written agreements subject to the Insurance Code Chapter 4151 with insurers or plan sponsors in this state is not required to file an audited financial statement under the Insurance Code §4151.205(c), but must file a financial statement certified in the manner prescribed by Commissioner rule. The Insurance Code §4151.206(a) provides that the Commissioner shall collect and an applicant or administrator shall pay to the Commissioner, in an amount to be determined by the Commissioner, a filing fee not to exceed $1,000 for processing an original application for a certificate of authority for an administrator, a fee not to exceed $500 for an examination under the Insurance Code §4151.201, and a filing fee not to exceed $200 for an annual report. The Insurance Code §4151.211(a) provides that a person may not

acquire an ownership interest in an entity that holds a certificate of authority under the Insurance Code Chapter 4151 if the person is, or after the acquisition would be, directly or indirectly in control of the certificate holder, or otherwise acquire control of or exercise any control over the certificate holder, unless the person has filed with the Department under oath a biographical form for each person by whom or on whose behalf the acquisition of control is to be effected; a statement certifying that no person who is acquiring an ownership interest in or control of the certificate holder has been the subject of a disciplinary action taken by a financial or insurance regulator of this state, another state, or the United State; a statement certifying that, immediately on the change of control, the certificate holder will be able to satisfy the requirements for the issuance of a certificate of authority; and any additional information that the Commissioner by rule may prescribe as necessary or appropriate to the public interest and the protection of the insurance consumers of this state. The Insurance Code §4151.211(b) provides that the Department may require a partnership, syndicate, or other group that is required to file a statement under the Insurance Code §4151.211(a) to provide the information required under the Insurance Code §4151.211(a) for each partner of the partnership, each member of the syndicate or group, and each person who controls the partner or member. Further, under the Insurance Code §4151.211(b), if the partner, member, or person is a corporation or the person required to file the statement under the Insurance Code §4151.211(a) is a corporation, the Department may require that the information required under the Insurance Code §4151.211(a) be provided regarding the corporation, each individual who is an executive officer or director of the corporation, and each person who is directly or indirectly the beneficial

owner of more than 10 percent of the outstanding voting securities of the corporation. The Insurance Code §4151.211(c) provides that the Department may disapprove an acquisition of control if, after notice and opportunity for hearing, the Commissioner determines that immediately on the change of control the certificate holder would not be able to satisfy the requirements for the certificate of authority; the competence, trustworthiness, experience, and integrity of the persons who would control the operation of the certificate holder are such that it would not be in the interest of the insurance consumers of this state to permit the acquisition of control; or the acquisition of control would violate the Insurance Code or another law of this state, another state, or the United States. Notwithstanding the Insurance Code §4151.211(c), the Insurance Code §4151.211(d) provides that a change in control is considered approved if the Commissioner has not proposed to deny the requested change before the 61st day after the date on which the Department receives all information required by the Insurance Code §4151.211. The Insurance Code §4151.212 provides that the Department may, in the manner prescribed by the Insurance Code §4151.056 and by the Insurance Code Chapter 4151, Subchapter G revoke, suspend, or refuse to renew the certificate of authority of a certificate holder who does not maintain the qualifications necessary to obtain a certificate of authority issued under the Insurance Code Chapter 4151. The Insurance Code §4151.253(a) provides that an administrator shall enter into a contract in connection with workers' compensation benefits for collecting premium or contributions, adjusting claims, or settling claims with the insurance carrier responsible for those claims, including the insurance carrier responsible for claims arising under policies authorized under the Insurance Code §2053.202(b). Further, a contract

required by the Insurance Code §4151.253(a) may be in the form of a master services agreement. The Insurance Code §4151.253(b) requires a contract required by the Insurance Code §4151.253(a) to provide that the contract does not limit in any way the insurance carrier's authority or responsibility, including financial responsibility, to comply with each statutory or regulatory requirement and that the administrator shall comply with each statutory or regulatory requirement relating to a function assumed by or carried out by the administrator. The Insurance Code §4151.257 provides that the Commissioner shall adopt rules to implement the requirements of the Insurance Code Chapter 4151, Subchapter F, including rules prescribing requirements for contracts and master services agreements and requirements for the payment of claims. Further, under the Insurance Code §4151.257, the rules must provide for compliance with the requirements of the Insurance Code Chapter 4151 for any contract that takes effect or has an annual anniversary date on or after January 1, 2008. The Insurance Code §4151.301 provides that the Department may deny an application for a certificate of authority or discipline the holder of a certificate of authority under the Insurance Code Chapter 4151, Subchapter G if the Department determines that the applicant or holder, individually, or through an officer, director, or shareholder has willfully violated an insurance law of this state; has intentionally made a material misstatement in the application for a certificate of authority; has obtained or attempted to obtain a certificate of authority by fraud or misrepresentation; has misappropriated, converted to the applicant's or holder's own use, or illegally withheld money belonging to an insurance carrier, as that term is defined by the Labor Code §401.011, an insurer, as that term is defined by the Insurance Code §4001.003, a health maintenance organization, or an

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

The Labor Code Chapter 407 regulates workers' compensation self insurance. The Labor Code §407.001(5) defines a qualified claims servicing contractor as a person who provides claims service for a certified self-insurer, who is a separate business entity from the affected certified self-insurer, and who holds a certificate of authority under the Insurance Code Chapter 4151.

The Labor Code Chapter 407A regulates workers' compensation group self insurance. The Labor Code §407A.009(a) requires an administrator or service company under the Labor Code Chapter 407A that performs the acts of an

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

The Labor Code Chapter 415 addresses Texas Workers' Compensation Act administrative violations. The Labor Code §415.0036(b) provides that a person described by the Labor Code §415.0036(a) commits an administrative violation if the person offers to pay, pays, solicits, or receives an improper inducement relating to the delivery of benefits to an injured employee or improperly attempts to influence the delivery of benefits to an injured employee, including through the making of improper threats. The Labor Code §415.0036(b) provides that §415.0036 applies to each person described by §415.0036(a) who is a participant in the workers' compensation system of this state and to an agent of such a person.

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

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

7. TEXT.

§7.1601. Scope.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) an individual or group annuity benefit; or

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

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

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

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

§7.1603. Certificate of Authority Required. Unless a person meets an exemption under the Insurance Code §§4151.002, 4151.0021, or 4151.004, a person acting as or holding itself out as an administrator must hold a certificate of authority under the Insurance Code Chapter 4151.

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

§7.1604. Application for Certificate of Authority.

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

(b) Forms and Fee.

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

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

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

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

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

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

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

(d) Biographical Affidavit.

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

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

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

§7.1605. Notification Requirements.

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

(2) of this subchapter (relating to Certificate of Authority Required, Application for Certificate of Authority, and Annual Report).

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

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

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

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

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

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

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

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

(A) ownership of voting securities;

(B) ownership by contract; or

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

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

(A) an administrator; or

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

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

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

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

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

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

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

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

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

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

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

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

§7.1608. Fidelity Bond.

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

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

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

§7.1609. Annual Report.

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

(b) Forms and Fee.

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

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

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

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

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

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

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

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

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

(d) Exemption.

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

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

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

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

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

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

§7.1610. Financial Statements under the Education Code.

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

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

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

(b) An administrator meeting the requirements of subsection (a) of this section may comply with the requirement for an audited financial statement under the Education Code §22.004(h) by providing a copy of the financial statement filed with the Department for the preceding calendar year that:

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

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

§7.1611. Operational Review and On-Site Audit.

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

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

(c) Notwithstanding subsection (a) of this section, an insurer is not required to review the operations of an administrator under subsection (a) of this section more than one time in the same fiscal year in which the insurer conducts an on-site audit of that administrator pursuant to subsection (b) of this section.

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

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

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

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

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

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

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

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

(e) The purpose of the on-site audit required by subsection (b) of this section is to verify the accuracy, integrity, and completeness of the information received during a review conducted by the insurer pursuant to subsection (a) of this section. In addition to the requirements of subsection (d) of this section, an on-site audit conducted by an insurer pursuant to subsection (b) of this section must also:

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

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

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

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

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

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

(h) All information and documentation related to a review or on-site audit shall be made available to the commissioner upon request and must remain on file with the insurer for at least five years from the date of the review or on-site audit.

§7.1612. Fiduciary Bank Accounts.

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

(b) An administrator collecting or receiving any premium shall comply with the Insurance Code §§4151.105, 4151.106, 4151.107, and 4151.108 and this section. An administrator who receives any premium on behalf of an insurer, HMO, plan sponsor, or

group shall report the receipt of that premium to the insurer, HMO, plan sponsor, or group within a reasonable amount of time.

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

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

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

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

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

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

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

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

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

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

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

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

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

§7.1613. Written Agreements Between Administrators and Insurers.

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

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

(c) A written agreement entered into under this section may not be construed to limit, in any way, an insurer’s ultimate accountability and responsibility for compliance

with all statutory and regulatory requirements under the Insurance Code, the Labor Code, and rules adopted thereunder.

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

(1) a requirement that the administrator must comply with all statutory, contractual, and regulatory requirements related to a function assumed or carried out by the administrator and related to a plan for which the administrator performs or offers to perform administrative services;

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

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

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

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

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

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

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

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

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

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

§7.1614. Prohibited Acts.

(a) An administrator is prohibited from:

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

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

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

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

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

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

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

§7.1615. Transfer of Books and Records.

(a) Unless otherwise approved by the commissioner, no later than 30 days from the date of the termination of the relationship or written agreement between an insurer, HMO, plan sponsor, or group and an administrator, the administrator shall provide a complete and accurate original set or a complete and accurate copy or image of the original set of the insurer's, HMO's, plan sponsor's, or group's books and records:

(1) to a successor administrator; or

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

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

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

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

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

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

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

§7.1616. Hazardous or Injurious Operating Conditions.

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

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

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

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

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

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

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

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

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

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

(b) Other facts and circumstances not specified in subsection (a) of this section, as determined by the commissioner, that relate to the financial condition or business operations or conduct of an applicant or administrator in this state may also indicate that an applicant or administrator is operating in a hazardous or injurious manner.

§7.1617. Examinations.

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

(b) Pursuant to the Insurance Code §4151.202, prior to an examiner entering the property of an administrator, written notice shall be given to the administrator. The written notice shall include the date and estimated time the examiner will enter the property of the administrator.

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