SUBCHAPTER A. Examination and Financial Analysis
28 TAC §7.88

1. INTRODUCTION. The Texas Department of Insurance proposes new §7.88, concerning independent annual audits of insurer and health maintenance organization (HMO) financial statements. The proposed new rule is necessary to improve the Department's surveillance of the financial condition of insurers and HMOs by (i) specifying the requirements of an annual audit of the financial statements reporting the financial condition and the results of operations of each insurer or HMO by an independent certified public accountant or accounting firm that meets the requirements of the Insurance Code §401.011 (independent accountant); (ii) requiring communication of internal control related matters noted in an audit; (iii) requiring each insurer or HMO that is required to file an annual audited financial report under the Insurance Code Chapter 401, Subchapter A, to have an audit committee; and (iv) requiring certain insurer or HMO management to prepare and file a report of the insurer's or HMO's or group of insurers' or HMOs' internal control over financial reporting. The phrase *group of insurers or HMOs* is defined in proposed new §7.88(c)(5) as "Those authorized insurers or HMOs included in the reporting requirements of the Insurance Code Chapter 823, or a set of insurers or HMOs as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting." The Insurance Code Chapter 401, Subchapter A requires an annual audit by an independent accountant of the financial statements reporting the

financial condition and the results of operations of each insurer or HMO, subject to certain specified requirements and exemptions. The provisions of Chapter 401, Subchapter A, are based primarily upon the independent annual audit requirements specified in the *Model Regulation Requiring Annual Audited Financial Reports* (Model Audit Rule or MAR), which was originally adopted by the National Association of Insurance Commissioners (NAIC) in 1980. The proposed new rule is necessary to adopt significant updates to the MAR. These updates were adopted by the NAIC and the American Institute of Certified Public Accountants (AICPA) Working Group in June of 2006. The revised MAR, called the *Annual Financial Reporting Model Regulation*, incorporates best practice standards and elements of the Sarbanes-Oxley Act of 2002 (SOX) relating to accountant qualifications and independence, corporate governance, and internal control over financial reporting for both non-public and public insurers and HMOs. The proposed new rule is necessary to adopt these updated standards and requirements in order to (i) improve the Department's surveillance of the financial condition of insurers and HMOs; (ii) clarify, implement, and augment the independent audit requirements of the Insurance Code Chapter 401, Subchapter A; (iii) enable the Department to detect and take appropriate action to address situations in which an insurer or HMO is in a financial condition or is operating or conducting business in a manner that would render further transaction of business in this state hazardous to the policyholders, enrollees, or creditors of the insurer or HMO or to the public, as contemplated under the Insurance Code Chapters 404, 441, and 843; (iv) ensure the qualifications and

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

The implementation guide being developed by the NAIC is expected to be an informational appendix to the NAIC Accounting Practices and Procedures Manual (AP&P Manual). The AP&P Manual with updates is adopted by reference under §7.18, with certain specified exceptions or additions. The inclusion of the implementation guide is expected to reduce the costs and time of implementation by insurers and HMOs subject to the requirements in the proposed new rule.

New Requirements Clarify, Implement, and Augment Statutory Requirements

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

Indebtedness; Audited Financial Reports; and Investments, Loans, and Other Assets, respectively). For example, §7.85 (relating to Audited Financial Reports) specifically implements the Insurance Code §401.009(d). Section 401.009(d) provides that the Commissioner shall adopt rules governing the information to be included in the audited financial report under the Insurance Code §401.009(a)(3)(H). Proposed new §7.88(b)(1) specifies that except as otherwise specified in the Insurance Code Chapter 401, Subchapter A, and in §7.88, the §7.88 requirements apply to insurers and HMOs and takes effect beginning with the annual reporting period ending December 31, 2010, which period is reflected in reports and communications required to be filed with the Commissioner during calendar year 2011, and continues in effect each year thereafter. Chapter 401, Subchapter A, enumerates several exemptions from the various independent audit requirements. Therefore, proposed new §7.88 must be read in conjunction with certain exemptions specified in Chapter 401, Subchapter A, including an exemption provided under §401.006 for certain small insurers or HMOs and an exemption provided under §401.007 for certain foreign or alien insurers or HMOs. Section 401.006(a) provides that an insurer or HMO that has less than $1 million in direct premiums written in this state during a calendar year is exempt from the requirement to file an audited financial report under §401.004 if the insurer or HMO also has less than $1 million in nationwide assumed premiums under reinsurance agreements during a calendar year and submits an affidavit, made under oath by one of the insurer's or HMO’s officers, that specifies the amount of direct premiums written in this state during that period.

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

under certain specified circumstances, such as the insurer or HMO being placed under supervision, conservatorship, or receivership during the five-year period preceding the date the application for the exemption is made. The applicability of an exemption under §401.008 would extend to the requirements specified in proposed new §7.88. Additionally, for example, proposed new §7.88(f) specifically describes the requirements for the financial statements in the audited financial report, but the proposed new rule does not otherwise specifically address the content of the audited financial report. The Insurance Code §401.009, however, does expressly describe the requirements governing the content of audited financial reports. Moreover, pursuant to §401.009(a)(3)(H) and (d), §7.85 addresses the information that must be included in the audited financial reports in order for the Department to conduct insurer or HMO examinations under the Insurance Code Chapter 401, Subchapter B. Section 7.18 adopts the NAIC's Accounting Practices and Procedures Manual (Manual) as the guideline for statutory accounting principles in Texas to the extent the Manual does not conflict with provisions of the Insurance Code or rules of the Department, including those rules specifically listed in §7.18(a). Therefore, in order to properly discern the content requirements for audited financial reports required to be filed under the Insurance Code §401.004, it is necessary to review not only the provisions of proposed new §7.88, but also the provisions of the Insurance Code Chapter 401, Subchapter A, including §401.009, as well as various regulations adopted by the Department in Chapters 3, 7, and 11 of Title 28, including §7.18 and §7.85.

The Impact on the Regulator's Financial Condition Examinations

The proposed new requirements are important in identifying insurers' or HMOs' potentially hazardous financial conditions so that corrective actions, if necessary, may be taken by the Department or by the insurers or HMOs to alleviate or prevent harm to the public and insurance consumers of this state at the earliest point in time. The proposed new requirements mandate that certain insurers and HMOs generate, maintain, and report financial information that is necessary for the Department to conduct the insurer's or HMO's examination under the Insurance Code Chapter 401, Subchapter B. Specifically, proposed new §7.88(m)(1) and (7) require the management of certain insurers or HMOs (e.g., those that have $500 million or more of annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program) to annually prepare and file a management's report of internal control of financial reporting with the Commissioner and to document and make available upon financial condition examination, the basis of management's opinions required under proposed new §7.88(m)(5). The term *internal control over financial reporting* that is required in proposed new §7.88(m)(1) is defined in proposed new §7.88(c)(8) as "A process implemented by an entity's board of directors, management, and other personnel designed to provide reasonable assurance regarding the reliability of the entity's financial statements. The term includes policies and procedures that: (A) relate to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets; (B) provide reasonable

assurance that: (i) transactions are recorded as necessary to permit preparation of the financial statements; and (ii) receipts and expenditures are made only in accordance with authorizations of management and directors; and (C) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of assets that could have a material effect on the financial statements." Additionally, proposed new §7.88(j) requires each insurer or HMO to provide to the Commissioner, not later than the 60th day after the date the annual audit report required by the Insurance Code Chapter 401, Subchapter A (audited financial report), is filed with the Commissioner, an annual written communication prepared by an independent accountant that describes any unremediated material weaknesses in its internal controls over financial reporting noted during the audit. Also, proposed new §7.88(k)(11) directs the insurer's or HMO's audit committee to require the independent accountant who performs an audit required by the Insurance Code Chapter 401, Subchapter A, and §7.88 to report to the audit committee in accordance with the requirements of Statement on Auditing Standards No. 114, "The Auditor's Communication With Those Charged With Governance," or a successor document. Further, in accordance with the Insurance Code §401.013(a)(3)(D) and §401.020, an insurer or HMO required to file an audited financial report must require its accountant, who is qualified and independent in accordance with the requirements in the Insurance Code §401.011 and in proposed new §7.88(h), to retain and make available the independent accountant's work papers and any record of communications between the independent accountant and insurer or HMO relating to the

independent accountant's audit that were prepared in conducting the audit for review by the Department. As a result of these new requirements, the Department will have access to insurers' and HMOs' audited financial reporting documentation, including the independent accountant's work papers and related or supporting communications. This will enable the Department to properly regulate and monitor the financial condition and operations of insurers and HMOs, including any unremediated material weaknesses in their internal control structures. Such unremediated material weaknesses may potentially impair the reliability, accuracy and usefulness of the financial statements prepared by those insurers and HMOs, filed with the Department, and relied upon by the Department for solvency regulation. More specifically, the Department's receipt of the information required by the new requirements will enable the Department to identify those insurers and HMOs that either are: (i) taking timely, appropriate, and reasonable action to address and correct financial problems, including unremediated material weaknesses in their internal controls, or (ii) not taking timely, appropriate, and reasonable action to address these concerns, which may result in a potentially hazardous financial condition. The Department anticipates encouraging insurers and HMOs in the latter category to take action voluntarily to address any financial condition issues, including internal control deficiencies. The Department may require that such action be taken in certain instances when potentially hazardous conditions exist. Thus, the Department anticipates the information required will reduce the incidences of future or ongoing financial problems, including unremediated material weaknesses in

internal controls, and by extension, will reduce the risk of future insurer and HMO solvency concerns.

Audit Committee Requirements and Management Internal Control Reporting Requirements

Two of the most important changes proposed in the new section are the audit committee requirements and the management internal control over financial reporting requirements. Some of the more significant changes relating to these two areas are summarized in this paragraph. Proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), (k), and (n)(1) address the new audit committee requirements for certain insurers and HMOs that are not completely exempt from the proposed new §7.88 requirements pursuant to the Insurance Code §401.006 or §401.008, or under §401.007 and proposed new §7.88(e)(1). These proposed audit committee requirements are expected to enhance corporate governance and internal controls over financial reporting for the benefit of policyholders, enrollees, creditors, and the public generally. Specifically, proposed new §7.88(c)(3) and (d)(5) require all non-exempt insurers and HMOs to designate a group of individuals to serve as its audit committee, and if one is not designated, the insurer's or HMO's entire board of directors will constitute the audit committee. Proposed new §7.88(d)(5) also provides that the audit committee of an entity that controls an insurer or HMO may, at the election of the controlling person, be deemed to be the insurer's or HMO's audit committee for purposes of §7.88. Section 7.88(b)(3) provides that the specific audit committee requirements in §7.88(k) take effect on August 1, 2010**,** whereas the due date for filing the

management's report of internal control over financial report required under proposed new §7.88(m)(1) will be in calendar year 2011 for the 2010 reporting period. Proposed new §7.88(k)(1) exempts the following types of insurers and HMOs from the proposed new audit committee requirements in §7.88(k)(2) and (4) – (12): (i) a foreign or alien insurer or HMO; (ii) an insurer or HMO that is a SOX-compliant entity as defined in proposed new §7.88(c)(13); (iii) an insurer or HMO that is a direct or indirect wholly owned subsidiary of a SOX-compliant entity; and (iv) a non-stock insurer that is under the direct or indirect control of a SOX-compliant entity, including pursuant to the terms of an exclusive management contract. The NAIC's implementation guide explains that the exception in proposed new §7.88(k)(1) was placed within the revised MAR to avoid conflicts between the independence requirements of the revised MAR and those required of public companies under Section 301 of the SOX. The expectation of the Department in developing this exception was that the same independent audit committee required of public companies under Section 301 would be deemed to be the insurer's or HMO's audit committee for purposes of this regulation or would participate in the oversight of the insurers or HMOs within the group. Therefore, if material weaknesses, significant deficiencies, and/or significant solvency concerns are identified at the legal entity level, the independent audit committee should be involved in addressing these issues, regardless of their materiality at the consolidated, parent company level. Proposed new §7.88(c)(13) defines a *SOX-compliant entity* as an entity that is required to comply with or voluntarily complies with: (A) the preapproval

requirements provided by 15 U.S.C. Section 78j-1(i); (B) the audit committee independence requirements provided by 15 U.S.C. Section 78j-1(m)(3); and (C) the internal control over financial reporting requirements provided by 15 U.S.C. Section 7262(b) and Item 308, SEC Regulation S-K. Proposed new §7.88(k)(2)(A), (5), and (8) require non-exempt insurers or HMOs with over $500 million in direct written and assumed premiums for the preceding calendar year to have a supermajority (75 percent or more) of independent audit committee members. Proposed new §7.88(k)(2)(B), (5), and (8) require non-exempt insurers or HMOs with $300 million to $500 million in direct written and assumed premiums for the preceding calendar year to have a majority (50 percent or more) of independent audit committee members. Proposed new §7.88(k)(2)(C) and (5) provide that except as provided in §7.88(k)(3), a non-exempt insurer or HMO with less than $300 million in direct and assumed premiums for the preceding calendar year is not required to comply with the §7.88(k)(2) independence requirements for its audit committees. The insurers and HMOs subject to the proposed §7.88(k)(3) requirement are those insurers and HMOs for which the Commissioner requires the insurer's or HMO's board to enact improvements to the independence of the audit committee membership if the insurer or HMO (i) is in a risk-based capital action level event; (ii) meets one or more of the standards of an insurer or HMO considered to be in hazardous financial condition; or (iii) otherwise exhibits qualities of a troubled insurer or HMO. Proposed new §7.88(k)(4) authorizes an insurer or HMO with less than $500 million in direct written and assumed premiums (subject to certain

exclusions in determining the amount of direct written and assumed premiums specified in (k)(4) and (5)) to apply to the Commissioner for a hardship waiver from the independence requirements of proposed new §7.88(k)(1), (2), and (5) – (12). Proposed new §7.88(k)(5) provides that as used in §7.88(k), direct written and assumed premiums for the preceding calendar year shall be the combined total of direct premiums and assumed premiums from non-affiliates for the reporting entities. Proposed new §7.88(k)(6) provides that the audit committee of the insurer or HMO is directly responsible for the appointment, compensation, and oversight of the work of any independent accountant; and that each independent accountant shall report directly to the audit committee. Proposed new §7.88(k)(7) requires that each member of the audit committee be a member of the board of directors of the insurer or HMO or a member of the board or directors of an entity elected under proposed new §7.88(k)(10) and described under proposed new §7.88(c)(3). Proposed new §7.88(k)(6), (11), and (12) require each independent accountant to report certain specified information directly to the audit committee. Proposed new §7.88(k)(10), in conjunction with proposed new §7.88(c)(3), provides that the audit committee of an entity that controls an insurer or HMO may, at the election of the controlling person, be the insurer's or HMO's audit committee.

Proposed new §7.88(m)(1) requires certain large insurers or HMOs required to file an audited financial report under the Insurance Code Chapter 401, Subchapter A, and proposed new §7.88 to prepare an annual management report of the insurer's or HMO's internal control over financial reporting and

submit that report annually to the Commissioner. The insurers and HMOs subject to proposed new §7.88(m)(1) have $500 million or more in annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, and that do not meet an exemption provided under §401.006 or §401.008, or under §401.007 and proposed new §7.88(e)(1). Proposed new §7.88(m)(3) and (4) allows, under certain specified conditions, an insurer or HMO or a group of insurers or HMOs to file with the Commissioner the insurer's or HMO's or the insurer's or HMO's parent's Section 404 report, as that term is defined in proposed new §7.88(c)(11), and an addendum, as described in proposed new §7.88(m)(4), if the insurer or HMO or group of insurers or HMOs is (A) directly subject to Section 404, (B) part of a holding company system whose parent is directly subject to Section 404, (C) not directly subject to Section 404 but is a SOX-compliant entity, or (D) a member of a holding company system whose parent is not directly subject to Section 404 but is a SOX-compliant entity. The Section 404 report is required by Section 404 of the SOX. The conditions specified in proposed new §7.88(m)(4) are: (i) a Section 404 report must include those internal controls of the insurer or HMO or group of insurers or HMOs that have a material impact on the preparation of the insurer's or HMO's or group of insurers' or HMOs' audited statutory financial statements, including those items specified in the Insurance Code §401.009(a)(3)(B) – (H) and (b); and (ii) the addendum required to be filed under proposed new §7.88(m)(3) must be a positive statement that there are no material processes excluded from the

Section 404 report with respect to the preparation of the insurer's or HMO's or group of insurers' or HMOs' audited statutory financial statements, including those items specified in the Insurance Code §401.009(a)(3)(B) – (H) and (b). Proposed new §7.88(m)(4) further requires that if there are internal controls of the insurer or HMO or group of insurers or HMOs that have a material impact on the preparation of the insurer's or HMO's or group of insurers' or HMOs' audited statutory financial statements and those internal controls are not included in the Section 404 report, the insurer or HMO or group of insurers or HMOs may either file a management report under proposed §7.88(m)(1) or the Section 404 report and a report under proposed §7.88(m)(1) for those internal controls that have a material impact on the preparation of the insurer's or HMO's or group of insurers' or HMOs' audited statutory financial statements not covered by the Section 404 report. Proposed new §7.88(m)(5) – (8) identifies management's responsibilities for internal control over financial reporting. Proposed new §7.88(m)(7) requires the management of an insurer or HMO to document and make available upon financial condition examination, the basis of the opinions required by proposed §7.88(m)(5). These proposed internal controls over financial reporting requirements provide the Department with additional assurances of the effectiveness of an insurer's or HMO's internal control practices in a cost effective manner. Management's assertions about the effectiveness of the company's internal controls over financial reporting enhance oversight and understanding of insurer and HMO solvency by allowing the Department to have greater confidence in the accuracy and reliability of financial reporting, which

benefits policyholders, enrollees, creditors, and the public generally. An additional expected benefit of this enhancement, where internal controls over financial reporting are effective, is the anticipation by the Department that financial examinations will become more efficient and risk-focused. Additionally, similar to SOX Section 404, the proposed new requirements prohibit management from determining that internal controls over financial reporting are effective if one or more unremediated material weaknesses exist as of the balance sheet date. Unlike under SOX Section 404, proposed new §7.88(m) does not require that an insurer's or HMO's independent accountant provide an attestation report on the effectiveness of internal controls over financial reporting.

New Lead Audit Partner Limitation

Proposed new §7.88(h) specifies the accountant qualifications and independence standards and requirements relating to the Commissioner's acceptance of audited financial reports from an independent accountant. Proposed new §7.88(b)(2) and (h)(1) provides certain limitations on the number of years that an audit partner may serve in the capacity of lead audit partner or other person responsible for rendering an audited financial report for an insurer or HMO. These proposed limitations go into effect for audits of the year beginning January 1, 2010, which audits are reflected in reports and communications required to be filed with the Commissioner during calendar year 2011, and continues in effect each year thereafter. These proposed limitations are modeled after and consistent with the limitations in the revised NAIC Model Rule. Under the Insurance Code §401.011(c), a partner or other person

responsible for rendering an audit report for an insurer or HMO for seven consecutive years may not, during the two-year period after that seventh year, render an audit report for the insurer or HMO or for a subsidiary or affiliate of the insurer or HMO that is engaged in the business of insurance. Section 401.011(c) further provides that the Commissioner may determine that this limitation does not apply to an accountant for a particular insurer or health maintenance organization if the insurer or HMO demonstrates to the satisfaction of the Commissioner that the application of the limitation to the insurer or HMO would be unfair because of unusual circumstances. In making the determination, the Commissioner may consider: (i) the number of partners or individuals the accountant employs, the expertise of the partners or individuals the accountant employs, or the number of the accountant's insurance clients; (ii) the premium volume of the insurer or health maintenance organization; and (iii) the number of jurisdictions in which the insurer or health maintenance organization engages in business. Under proposed new §7.88(h)(1), the lead audit partner or other person responsible for rendering an audited financial report for an insurer or HMO may not act in that capacity for more than five consecutive years and may not, during the five-year period after that fifth year, render a report for the insurer or HMO or for a subsidiary or affiliate of the insurer or HMO that is engaged in the business of insurance unless the insurer or HMO requests an exemption. Under proposed new §7.88(h)(1), the insurer or HMO may submit a written application to the Commissioner at least 30 days before the end of the calendar year for an exemption from the proposed new §7.88(h)(1) accountant

qualifications and independence requirement. The Commissioner may determine that the limitation does not apply for a particular insurer or HMO if the insurer or HMO demonstrates to the satisfaction of the Commissioner that the application of the limitation to the insurer or HMO would be unfair because of unusual circumstances. In making the determination, the Commissioner may consider: (i) the number of partners or individuals the accountant employs, the expertise of the partners or individuals the accountant employs, or the number of the accountant's insurance clients; (ii) the premium volume of the insurer or HMO; and (iii) the number of jurisdictions in which the insurer or HMO engages in business. The five-year limitation under proposed new §7.88(h)(1) is necessary for the following reasons. First, it is part of the 2006 updates necessary for the Department to maintain its NAIC accreditation after January 1, 2010. The provisions of the Insurance Code Chapter 401, Subchapter A, including §401.011(c) that specifies the seven-year limitation for a partner or other person responsible for rendering an audited financial report for an insurer or HMO, are based primarily upon the independent annual audit requirements specified in the MAR, which was originally adopted by the NAIC in 1980. Significant updates to the MAR, including the proposed five-year limitation for independent accountants in §7.88(h)(1), were adopted by the NAIC and the AICPA Working Group in June of 2006. The revised MAR incorporates best practice standards and elements of SOX relating to accountant qualifications and independence, corporate governance, and internal control over financial reporting for both non-public and public insurers and HMOs. The proposed five-

year limitation in §7.88(h)(1) is consistent with the new rotation limitation prescribed under the NAIC's revised MAR, which is to be effective beginning with audits of the 2010 financial statements and is expected to be substantially adopted by other states prior to or during calendar year 2010. Thus, insurers and HMOs that are licensed or authorized to conduct the business of insurance in another state will be expected to meet the proposed five-year limitation in calendar year 2010 in order to comply with the other state's laws. Second, it is necessary to effectuate the accountant independence requirements in the Insurance Code §§401.011 – 401.014. Pursuant to §§401.011 - 401.014, the Commissioner has the responsibility to ensure the independence and qualifications of accountants engaged by insurers and HMOs to prepare the statutorily required annual audited financial reports. The Department anticipates a number of benefits will result from increasing the independent accountant rotation frequency, including, but not limited to, that a lead auditor partner will (i) be less prone to become overly comfortable with an insurer's or HMO's methods of operations, internal controls and accounting systems, thereby decreasing the risk that the independent accountant will place unwarranted reliance on the accuracy of the insurer's or HMO's financial reports; (ii) be less prone to become overly comfortable with the insurer's or HMO's staff, officers and directors, thereby decreasing the risk that the lead audit partner will fail to exhibit appropriate impartiality or independent judgment, and/or adequately question and investigate the veracity of representations made to the lead audit partner during the course of the audit; and (iii) be more likely to exhibit a tendency to ask

probing questions that ultimately relate to the reliability of the insurer's or HMO's accounting systems and internal controls, and the accuracy of the insurer's or HMO's reported financial condition. Accordingly, the proposed limitation will help to ensure the independence of the lead audit partner from the insurer or HMO being audited. Third, the limitation under proposed new §7.88(h)(1) is necessary to implement and/or supplement several financial solvency regulatory statutes, including, the Insurance Code (i) §32.041, concerning statement blanks and other reporting forms necessary for companies to comply with the filing requirements; (ii) Chapters 404 and 843, concerning an insurer's or HMO's hazardous financial condition; (iii) Chapters 441 and 843, concerning the rehabilitation and conservation of insurers and HMOs; (iv) §421.001, concerning the adoption of each current NAIC formula for establishing reserves applicable to each line of insurance; and (v) §§802.001 - 802.003 and 802.051 - 802.056, concerning the Commissioner's authority to make changes in the forms of the annual statements required of insurance companies of any kind, as necessary to obtain an accurate indication of the company's condition and method of transacting business, and to require certain insurers to make filings with the NAIC. Fourth, the Commissioner is required to protect insureds, enrollees or creditors, and the public against an insurer or HMO becoming insolvent, delinquent, or in a condition that renders the continuance of its business hazardous to its insureds, enrollees or creditors, or to the public, as contemplated under Chapters 404, 441, and 843. Proposed new §7.88(h)(1) provides an important tool for the Commissioner to accomplish this responsibility.

The increased minimum rotation of lead audit partners will result in improvements in the qualifications and independence of the lead audit partner, which the Department believes will result in financial books and records, financial statements, and audited financial reports that are more likely to be complete, current, reliable, and reflect the true and correct financial condition and operational results of the insurer or HMO being audited. This is because an accountant that is more highly qualified and truly independent will be more likely to conclude in an audited financial report, when appropriate, that an insurer or HMO is operating in a hazardous financial condition as compared to an accountant that is less qualified and independent. Conversely, allowing a lead audit partner to be less qualified or independent, or allowing a lead audit partner that has a potential conflict of interest, will increase the risk that the accountant will give a clean audited financial report, or understate the severity of issues found during the audit, for insurers or HMOs that may be operating in a hazardous financial conditions. The Commissioner relies on the audited financial report and the accountant's opinion in monitoring and regulating the insurer's or HMO's financial position and operations. Thus, it is crucial that the accountant be completely independent from the insurer or HMO in expressing an opinion on the financial statement in an audited financial report filed under Chapter 401, Subchapter A. Proposed new §7.88(h)(1) will help to ensure this independence and impartiality, and therefore, enhance the ability of the Department to actively monitor and regulate the financial condition and operations of insurers and HMOs. Therefore, although proposed new §7.88(h)(1) provides a more

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

Summary of Proposed Subsections. The following is a summary of the proposed subsections.

Proposed new §7.88(a) states the purpose of the proposed new section.

Proposed new §7.88(b) sets forth the applicability of the proposed new section. Proposed new §7.88(b)(1) specifies that except as otherwise specified in that section and in the Insurance Code Chapter 401, Subchapter A, this section applies to insurers and HMOs and takes effect beginning with the annual reporting period ending December 31, 2010, which period is reflected in reports and communications required to be filed with the Commissioner during calendar year 2011, and continues in effect each year thereafter. Proposed new §7.88(b)(2) specifies that the lead audit partner independence requirements in §7.88(h)(1) shall be in effect for audits of the year beginning January 1, 2010**,** which audits are reflected in reports and communications required to be filed with the Commissioner during calendar year 2011, and continues in effect each year thereafter. Proposed new §7.88(b)(3) provides that the audit committee requirements in proposed §7.88(k) take effect August 1, 2010.

Proposed new §7.88(c) specifies definitions of certain terms or phrases when used in the section, including the terms or phrases *accountant*, *affiliate*, *audit committee*, *group of insurers or HMOs*, *management*, *SEC*, *Section 404*, and *Section 404 report*. Proposed new §7.88(c)(1) defines the term *Accountant* as "An independent certified public accountant or accounting firm that meets the requirements of the Insurance Code §401.011." Proposed new §7.88(c)(2) defines the term *Affiliate* as having the meaning assigned by the Insurance Code

§823.003. Proposed new §7.88(c)(3) defines the term *Audit committee* as "A committee established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or HMO or group of insurers or HMOs and audits of financial statements of the insurer or HMO or group of insurers or HMOs. At the election of the controlling person, the audit committee of an entity that controls a group of insurers or HMOs may be the audit committee for one or more of the controlled insurers or HMOs solely for the purposes of this section. If an audit committee is not designated by the insurer or HMO, the insurer's or HMO's entire board of directors constitutes the audit committee." Proposed new §7.88(c)(5) defines the phrase *group of insurers or HMOs* as "Those authorized insurers or HMOs included in the reporting requirements of the Insurance Code Chapter 823, or a set of insurers or HMOs as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting." Proposed new §7.88(c)(9) defines the term *management* as "The management of an insurer or HMO or group of insurers or HMOs subject to this section." Proposed new §7.88(c)(10) defines the term *SEC* as "The United States Securities and Exchange Commission." Proposed new §7.88(c)(11) defines the term *Section 404* as "Section 404, Sarbanes-Oxley Act of 2002 (15 U.S.C. Section 7262), and rules adopted under that section." Proposed new §7.88(c)(12) defines the phrase *Section 404 report* as "Management's report on internal control over financial reporting as determined by the SEC and the related attestation report of an accountant."

Proposed new §7.88(d)(1) – (4) sets out requirements for filing the annual audited financial reports, including a requirement that insurers and HMOs file the audited financial reports with the Commissioner on or before June 1 for the preceding calendar year, as compared to on or before June 30 under current Texas filing requirements, except as otherwise provided. Thus, insurers and HMOs will need to file their audited financial reports for calendar year 2010 on or before June 1, 2011, unless otherwise provided under the proposed new section.

Proposed new §7.88(d)(5) requires an insurer or HMO required to file an annual audited financial report under the Insurance Code Chapter 401, Subchapter A and the proposed new section to designate a group of individuals to serve as its audit committee. Proposed new §7.88(d)(5) further provides that the audit committee of an entity that controls an insurer or HMO may, at the election of the controlling person, be the insurer's or HMO's audit committee for purposes of §7.88.

Proposed new §7.88(e)(1) sets forth certain filing requirements for foreign or alien insurers or HMOs found by the Commissioner to meet the exemption provisions in the Insurance Code §401.007.

Proposed new §7.88(e)(2) specifies that a foreign or alien insurer or HMO required to file management's report of internal control over financial reporting in another state is exempt from filing the report in this state under proposed new §7.88(m)(1) if the other state has substantially similar reporting requirements and the report is filed with the commissioner in that state in the time specified.

Proposed new §7.88(f) specifies certain requirements for financial statements included in the audited financial report.

Proposed new §7.88(g) sets forth the scope of the annual audited financial report, which includes certain new requirements related to internal control over financial reporting.

Proposed new §7.88(h) specifies the accountant qualifications and independence standards and requirements of an audited financial report from an independent accountant filed with the Commissioner. Proposed new §7.88(h)(1) provides certain limitations on the number of years that an audit partner may serve in the capacity of lead audit partner or other person responsible for rendering an audited financial report for an insurer or HMO. These limitations are modeled after and consistent with the limitations provided in the revised NAIC MAR. Under current requirements, the lead audit partner is permitted to serve for seven consecutive years in that capacity with a two-year break in service. Under the revised requirements in proposed new §7.88(h)(1), the lead audit partner (or other person having primary responsibility for the audit) may not act in that capacity for more than five consecutive years with a five year break in service, unless the insurer or HMO submits a written application to the Commissioner at least 30 days before the end of the calendar year for an exemption from the limitation in this paragraph. Proposed new §7.88(h)(2) requires an insurer or HMO for which the Commissioner has approved an exemption under proposed new §7.88(h)(1) to file the approval with the states in which it is doing or is authorized to do business and with the NAIC. Proposed

new §7.88(h)(3) provides that, in providing services, the accountant shall not function in the role of management, audit the accountant's own work, or serve in an advocacy role for the insurer or HMO; or directly or indirectly enter into an agreement of indemnity or release from liability regarding the audit of the insurer or HMO. Proposed new §7.88(h)(4) states that the Commissioner may not recognize as qualified or independent an accountant, or accept an annual audited financial report that was prepared wholly or partly by an accountant, who provides an insurer or HMO at the time of the audit certain specified non-audit services that, if performed by the accountant, would impact the accountant's independence in relation to the insurer or HMO, subject to the exemption specified in proposed new §7.88(h)(6). Proposed new §7.88(h)(5) provides that notwithstanding proposed new §7.88(4)(D), an independent accountant and the independent accountant's actuary, under certain specified conditions, may provide certain actuarially oriented advisory services involving the determination of amounts recorded in the financial statements. Proposed new §7.88(h)(6) allows certain insurers and HMOs with direct written and assumed premiums of less than $100 million in any calendar year to apply for an exemption to the proposed §7.88(h)(4) prohibitions relating to the types of services or functions that the independent accountant is not allowed to provide to the insurer or HMO. Such insurers and HMOs may request an exemption from the requirements of proposed new §7.88(h)(4) by filing with the Commissioner a written statement explaining why the insurer or HMO should be exempt. Proposed new §7.88(h)(6) provides that the Commissioner may grant the exemption if the Commissioner

finds that compliance would impose an undue financial or organizational hardship on the insurer or HMO. Proposed new §7.88(h)(7) – (9) requires pre-approval by the audit committee of all auditing and non-audit services performed by the accountant, except as otherwise provided under §7.88(h)(7) – (9). Proposed new §7.88(h)(10) provides that the Commissioner may not recognize an accountant as qualified or independent for a particular insurer or HMO if a member of the board, the president, chief executive officer, controller, chief financial officer, chief accounting officer, or any other persons serving in an equivalent position for the insurer or HMO was employed by the accountant and participated in the audit of the insurer or HMO within one year prior to the due date of the most current statutory opinion. Proposed new §7.88(h)(10) also provides that an insurer or HMO may apply to the Commissioner for an exemption from the requirements of §7.88(h)(10) on the basis of unusual circumstances. Proposed new §7.88(h)(11) provides that the Commissioner shall not accept an audited financial report prepared wholly or partially by an individual or firm who the Commissioner finds (A) has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act (18 U.S.C. Section 1961 et seq.), or a state or federal criminal offense involving dishonest conduct; (B) has violated the insurance laws of this state with respect to a report filed under the Insurance Code Chapter 401, Subchapter A, or this section; (C) has demonstrated a pattern or practice of failing to detect or disclose material information in reports filed under the Insurance Code Chapter 401, Subchapter A, or this section; or (D) has directly or indirectly entered into

an agreement of indemnity or release of liability regarding an audit of an insurer. Proposed new §7.88(h)(12) requires the insurer or HMO to file, with its annual statement filing, the approval of an exemption granted under proposed new §7.88(h)(6) or (10) with the states in which it does or is authorized to do business and with the NAIC. An insurer or HMO must comply with the independent accountant registration requirements in the Insurance Code §401.014 in addition to the independent accountant requirements specified in proposed new §7.88(h).

Proposed new §7.88(i) requires that the audited financial report required under the Insurance Code §401.004 be accompanied by a letter, provided by the accountant who performed the audit, that includes the representations and statements required under the Insurance Code §401.013, and a representation that the accountant is in compliance with the requirements specified in proposed new §7.18(h).

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

Proposed new §7.88(k), in conjunction with proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), and (n)(1), addresses the audit committee requirements for

certain insurers or HMOs that are not completely exempt from the proposed new §7.88 requirements pursuant to the Insurance Code §401.006 or §401.008, or under §401.007 and proposed new §7.88(e)(1). Proposed new §7.88(c)(3) defines the term “audit committee” as a committee established by the board of directors of an entity for the purpose of overseeing (i) the accounting and financial reporting processes of an insurer or HMO or group of insurers or HMOs; and (ii) the audits of financial statements of the insurer or HMO or group of insurers or HMOs. Under proposed new §7.88(c)(3), (d)(5), and (h)(7) – (9), all non-exempt insurers or HMOs are required to have an audit committee charged with the appointment, compensation, and supervision of the insurer or HMO’s independent accountant. If a non-exempt insurer or HMO does not designate an audit committee, then proposed new §7.88(b)(3) provides that the non-exempt insurer or HMO’s entire board of directors shall constitute the audit committee. Proposed new §7.88(k)(1) exempts the following types of insurers and HMOs from the proposed new §7.88(k)(2) and (4) – (12) audit committee requirements: (i) a foreign or alien insurer or HMO; (ii) an insurer or HMO that is a SOX-compliant entity as defined in proposed §7.88(c)(13); (iii) an insurer or HMO that is a direct or indirect wholly owned subsidiary of a SOX-compliant entity; or (iv) a non-stock insurer that is under the direct or indirect control of a SOX-compliant entity, including pursuant to the terms of an exclusive management contract. Proposed new §7.88(k)(2) and (3) address the independence requirements for audit committee membership. Proposed new §7.88(k)(2)(B) requires non-exempt insurers or HMOs with $300 million to $500 million in preceding calendar year direct written and assumed

premiums to have a majority (50 percent or more) of audit committee members that are independent. Proposed new §7.88(k)(2)(A) requires non-exempt insurers or HMOs with over $500 million of preceding calendar year direct written and assumed premiums to have a supermajority (75 percent or more) of audit committee members that are independent. Proposed new §7.88(k)(2)(C) provides that except as provided in §7.88(k)(3), a non-exempt insurer or HMO with less than $300 million in direct and assumed premiums for the preceding calendar year is not required to comply with the §7.88(k)(2) independence requirements for its audit committee members. The insurers or HMOs subject to the proposed new §7.88(k)(3) requirement are those insurers and HMOs for which the Commissioner to require an insurer's or HMO's board to enact improvements to the independence of its audit committee membership if the insurer or HMO meets certain specified circumstances. Proposed new §7.88(k)(4) allows an insurer or HMO with less than $500 million in direct written and assumed premiums (subject to certain exclusions in determining the amount of direct written and assumed premiums specified in §7.88(k)(4) and (5)) to apply to the Commissioner for a hardship waiver from the independence requirements of proposed new §7.88(k)(1), (2), and (5) – (12). Proposed new §7.88(k)(5) provides that in §7.88(k), direct written and assumed premiums for the preceding calendar year shall be the combined total of direct premiums and assumed premiums from non-affiliates for the reporting entities. Proposed new §7.88(k)(6) specifies certain responsibilities of insurer or HMO audit committees that relate to the independent accountant for the non-exempt insurer or HMO. Proposed new §7.88(k)(7) requires each member of the audit committee to be a member of the

board of directors of the insurer or HMO or, at the election of the controlling person, a member of the board of directors of an entity that controls the group of insurers or HMOs as provided under §7.88(k)(10). Proposed new §7.88(k)(8) specifies what constitutes "independence" for a member of the audit committee for purposes of §7.88(k). Proposed new §7.88(k)(9) provides that if an audit committee member ceases to be independent for reasons outside the member's reasonable control, the member may remain an audit committee member of the responsible entity for a certain specified time period. The responsible entity, however, must provide notice to the Commissioner as specified in proposed §7.88(k)(9)(A) and (B). Proposed new §7.88(k)(10), in conjunction with proposed new §7.88(c)(3) and (k)(7), describes the process for the controlling person to exercise its election to designate an audit committee of an entity that controls an insurer or HMO solely for purposes of §7.88. Proposed new §7.88(k)(11) and (12) specify independent accountant reporting requirements to the audit committee. Under proposed new §7.88(b)(3), the audit committee requirements in proposed new §7.88(k) take effect August 1, 2010.

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

Proposed new §7.88(m)(1) requires an insurer or HMO with greater than $500 million in direct written and assumed premium, excluding premiums reinsured

with the Federal Crop Insurance Corporation and the National Flood Insurance Program, to prepare and file a management report of internal control over financial reporting with the Commissioner, unless the insurer or HMO meets an exemption provided under §401.006 or §401.008, or under §401.007 and proposed new §7.88(e)(2). Proposed new §7.88(m)(2) provides that the Commissioner may require an insurer or HMO regardless of the amount of the annual direct written and assumed premiums to file the management's report of internal control over financial reporting if the insurer or HMO is in any risk-based capital level event or meets one or more of the statutory hazardous financial condition standards. The requirements and process for preparing and filing the management report are specified in detail in proposed new §7.88(m)(1) – (8). Proposed new §7.88(m)(3) and (4) specify certain options from the management report requirements in proposed new §7.88(m)(1) or (2) for certain insurers or HMOs or a group of insurers or HMOs that file the insurer's or HMO's or the insurer's or HMO's parent's Section 404 report and an addendum with the Commissioner.

Proposed new §7.88(n)(1) sets forth certain transition dates for certain insurers or HMOs whose audit committee as of August 1, 2010, is not subject to the independence requirements of proposed new §7.88(k)(2)(A) or (B) because the total premium is below the threshold specified in that subsection, and that later becomes subject to one of the independence requirements because of increases in the amount of premium. Proposed new §7.88(n)(2) requires an insurer or HMO or group of insurers or HMOs that is not required by proposed new §7.88(m)(1) to file a report beginning with the reporting period ending

December 31, 2010, because the total written premium is below the required threshold amount, to file a report no later than two years after the year in which the written premium exceeds the required threshold amount to file a report.

Proposed new §7.88(o) sets forth the severability provisions for the proposed new section.

2. FISCAL NOTE. Danny Saenz, Senior Associate Commissioner, Financial Program, has determined that for each year of the first five years the proposed section is in effect, there will be no fiscal implications for state or local government as a result of this section, and there will be no effect on local employment or the local economy.

3. PUBLIC BENEFIT/COST NOTE. Mr. Saenz also has determined that for each year of the first five years the proposed new section is in effect, there are numerous anticipated public benefits as a result of the proposal being in effect. Mr. Saenz has further determined that there will be potential costs for persons required to comply with the proposal.

Anticipated Public Benefits. The anticipated public benefits include: (i) a more efficient and standardized process for monitoring and regulating the financial condition and operations of insurers and HMOs; (ii) greater reliability, transparency, and consistency of financial statements prepared by insurers or HMOs and filed with the Department as well as improved comparability of financial statements received by the Department from an insurer or HMO over

various points in time and from different insurers and HMOs; this will result in increased ability and confidence of the Department and the public to rely on the accuracy of these financial statements; (iii) required disclosure of unremediated material weaknesses in an insurer's or HMO's internal control over financial reporting that may impair the reliability of the information reported in the financial statements; (iv) improved insurer or HMO corporate governance, internal controls over financial reporting to safeguard against fraud and mismanagement, and accountant independence and qualifications; (v) improved insurer or HMO operating performance, automation processes, corporate culture, and financial returns; (vi) enhanced insurer or HMO communications directly to the insurer's or HMO's appropriate decision-makers at the board of directors level who have the authority to help ensure that corrective action is timely implemented, thereby mitigating the risk that financial concerns will go undetected or unremediated, or will grow out of control; these proposed requirements also are intended to prevent or minimize situations in which information the board of directors or its audit committee may reasonably require from the external auditor is intercepted, managed, and potentially changed before such information gets to the board of directors or audit committee; (vii) improved monitoring of an insurer's or HMO's financial risk and the Department's surveillance of the financial condition and operations of insurers and HMOs, including their solvency; (viii) improved accuracy and reliability of financial data through the incorporation, documentation, testing, implementation and monitoring of appropriate processes, policies, procedures, controls, and systems; (ix) mitigation of the risk that an

insurer or HMO may be in a financial condition or operating in a manner that would render further transaction of business in this state hazardous to the insurer's or HMO's policyholders or creditors or to the public, which, if left un-detected or un-remediated, may result in unpaid claims to policyholders and third-party beneficiaries; (x) enhanced ability of the Department and the insurer or HMO to take appropriate, timely action to protect the public against the threat that an insurer or HMO may be operating in a potentially hazardous condition; this timely, appropriate action is expected to reduce the risk that such a insurer or HMO will remain undetected for a prolonged period of time, during which the underlying financial concerns may grow in magnitude; and (xi) reduced threat of potential insurer or HMO insolvencies.

Additionally, because this proposal requires both public and nonpublic insurers and HMOs, except where exempted or excepted, to comply with certain minimum standards and requirements relating to corporate governance, internal controls and auditing, the proposed requirements will help to ensure that all ors regulated pursuant to the Insurance Code Chapter 401, Subchapter A, employ best practices in the financial conduct of their business, including in the material processes, procedures, and internal controls used to prepare the audited financial reports. Currently, insurers or HMOs whose securities are publicly traded and registered with the Securities and Exchange Commission (SEC) must meet certain federal SOX requirements relating to corporate governance, internal controls, and independent auditing standards. These SOX requirements are conservative in nature and reflect best practices that many established and

prudent insurers and HMOs follow either to comply with the federal SOX requirements or to comply on a voluntary basis. However, the federal SOX requirements do not apply to non-public insurers and HMOs, and the Department anticipates that some of these exempt non-public insurers and HMOs may decline to voluntarily institute these best practices. Under the proposal, non-public insurers and HMOs will be required to comply with a number of SOX-like provisions that set forth uniform minimum-required corporate governance, internal controls, and independent auditing standards for both public and non-public insurers and HMOs. Therefore, this proposal will provide for greater uniformity and consistency in regulatory requirements for all insurers and HMOs required to undergo and file independent annual audits with the Department under the Insurance Code Chapter 401, Subchapter A, regardless of whether the insurers or HMOs are public or non-public insurers or HMOs. Another significant public benefit resulting from the adoption of this proposal is a more efficient and standardized process for insurers or HMOs that conduct the business of insurance in multiple states. Virtually all other state insurance departments have publicly indicated an intent to adopt minimum standards and requirements similar to the NAIC's current Model Audit Rule prior

Potential Costs for Persons Required to Comply with the Proposal.

Insurers or HMOs Exempt from All Proposed §7.88 Requirements. As explained in the Introduction section of this proposal, insurers or HMOs that meet either the exemption for certain small insurers and HMOs specified in the Insurance Code §401.006 or the hardship exemption specified in §401.008 for

any size of insurer or HMO will be exempt from all of the proposed new §7.88 requirements. The Department anticipates that some insurers or HMOs, including many small or micro business insurers or HMOs, will qualify for one of these two statutory exemptions. Under the Insurance Code §401.006, an insurer or HMO could apply to the Commissioner for an exemption if the insurer or HMO has less than $1 million in direct premiums written in this state during a calendar year and less than $1 million in nationwide assumed premiums under reinsurance agreements during a calendar year. Under the Insurance Code §401.008, an insurer or HMO that is not eligible for an exemption under §401.006 or §401.007 (foreign or alien insurers or HMOs) may apply to the Commissioner for a hardship exemption. The Commissioner may grant the hardship exemption if the Commissioner finds that compliance would constitute a severe financial or organizational hardship, except under certain statutorily specified circumstances. Such circumstances include the insurer or HMO being placed under supervision, conservatorship, or receivership during the five-year period preceding the date the application for the exemption is made. Any insurer or HMO meeting one of these two exemptions would not incur any new or additional costs to comply with proposed new §7.88.

Generally Exempt Foreign and Alien Insurers or HMOs Subject to Certain Proposed Requirements in New §7.88(e)(1). Foreign and alien insurers or HMOs that meet the exemptions in the Insurance Code §401.007(a) and proposed new §7.88(e) are exempt from all of the proposed new §7.88 requirements, except for the proposed new §7.88(e) filing requirements relating

to the submission to the Commissioner of copies of certain filings made in other states. Section 401.007 and proposed new §7.88(e)(1) exempt a foreign or alien insurer or HMO that files an audited financial report in another state in accordance with that state's audited financial report requirements from filing the audited financial report under Chapter 401, Subchapter A if the Commissioner finds that the other state's requirements are substantially similar to the requirements prescribed in Subchapter A. Proposed new §7.88(e)(1) primarily restates certain statutory filing requirements enumerated in the Insurance Code §401.007(b) and (c) for a foreign or alien insurer or HMO that meets the exemption specified under §401.007(a). These proposed filing requirements in proposed new §7.88(e)(1) are consistent with and similar to the current filing requirements prescribed in the Insurance Code §§401.004, 401.007(a) – (c), 401.013(a), 401.017, and 401.019. Proposed new §7.88(e)(1)(A) requires a foreign or alien insurer or HMO exempt under the Insurance Code §401.007(a) to file with the Commissioner a copy of the audited financial report filed with the insurer's or HMO's state of domicile and the accountant's letter of qualifications filed with the insurer's or HMO's state of domicile, at the same time these documents are filed with the state of domicile. Pursuant to §401.007(c), a foreign or alien insurer or HMO exempt under the Insurance Code §401.007(a) is currently statutorily required to file with the Commissioner a copy of the audited financial report and accountant's letter of qualifications filed with the other state in accordance with the filing dates prescribed by §401.004. Accordingly, the Department does not anticipate that there will be any additional or new cost of

compliance with proposed new §7.88(e)(1)(A) for foreign and alien insurers or HMOs exempt under the Insurance Code §401.007.

Proposed new §7.88(e)(1)(B) clarifies that an exempt foreign or alien insurer or HMO must file a copy of a communication of internal control-related matters noted in the audit that is substantially similar to the communication required under proposed new §7.88(j), not later than the 60th day after the date the copy of the audited financial report and accountant's letter of qualifications are filed with the Commissioner. Section 401.007 of the Insurance Code requires an exempt insurer or HMO that files a statutorily compliant report in another state to file with the Commissioner a copy of the report on significant deficiencies in internal controls filed with the other state. Section 401.019 of the Insurance Code requires an insurer or HMO to provide to the Commissioner a written report of significant deficiencies as required and prepared in accordance with the Professional Standards of the American Insurance of Certified Public Accountants. Section 401.019(c) also requires that the written report follow generally the form for communication of internal control structure matters noted in an audit described in Statement on Auditing Standard (SAS) No. 60, AU Section 325, Professional Standards of the American Institute of Certified Public Accountants. Proposed new §7.88(e)(1)(B) and (j) clarify the reporting contemplated under the Insurance Code §401.007 and §401.019. Proposed new §7.88(e)(1)(B) requires each insurer or HMO to provide the Commissioner with a copy of the written communication that is substantially similar to the communication required under proposed new §7.88(j). Proposed new §7.88(j)

requires an independent accountant to prepare the written communication in accordance with the Professional Standards of the American Institute of Certified Public Accountants that describes any un-remediated material weaknesses in its internal controls over financial reporting noted during the audit. Proposed new §7.88(j) also requires the written communication to contain a description of any un-remediated material weaknesses as of the immediately preceding December 31, as defined by SAS No. 112, "Communicating Internal Control Related Matters Identified in an Audit," or a successor document. These un-remediated material weaknesses must be included in the insurer's or HMO's communication of internal control over financial reporting and must have been noted by the accountant during the course of the audit of the financial statements. These proposed clarifications in §7.88(e)(1)(B) and (j) reflect the replacement during the summer of 2006 of the outdated SAS No. 60 with the new SAS No. 112 by the American Insurance of Certified Public Accountants Auditing Standards Board (ASB). The reporting required under proposed new §7.88(e)(1) is similar to the reporting required to be filed with the Department under the Insurance Code §401.007. Moreover, the Insurance Code §401.013(a)(3)(B) requires that an accountant provide a letter stating that the accountant conforms to the standards of the profession contained in the American Institute of Certified Public Accountants Code of Professional Conduct, the statements of the institute, and the rules of professional conduct adopted by the Texas State Board of Public Accountancy, or a similar code. For these reasons, including the fact that the ASB replaced the outdated SAS No. 60 with the new SAS No. 112, the

Department does not anticipate that proposed new §7.88(e)(1) will result in any costs of compliance that are in addition to those costs incurred by an insurer or HMO to comply with the reporting requirements in §401.007. Additionally, proposed new §7.88(e)(1)(C) also requires an exempt foreign or alien insurer or HMO to file with the Commissioner a copy of any notification of adverse financial conditions report filed with the other state, in accordance with the filing date prescribed by the Insurance Code §401.017. Because the proposed filing requirement in §7.88(e)(1)(C) is consistent with and similar to the current filing requirement prescribed in the Insurance Code §401.007(b)(2) and §401.017, it is not expected to result in any additional costs of compliance for foreign and alien insurers or HMOs subject to proposed new §7.88(e)(1).

Proposed new §7.88(b)(1) and (d)(1) - (4) Requirements for Non-Exempt Insurers or HMOs. In accordance with the discretion granted to the Commissioner under the Insurance Code §401.004(b), proposed new §7.88(d)(1) provides that except as provided in §7.88(d)(2), (3), and (4), an insurer or HMO that is required to file an annual audit performed by an independent accountant with the Commissioner must file the audited financial report on or before June 1 for the preceding calendar year. Proposed new §7.88(d)(2) provides that except as provided in §7.88(d)(3) and (4), an insurer or HMO that, along with any affiliated insurers or HMOs, is licensed in and does business only in Texas shall file the audited financial report with the Commissioner on or before June 30 for the preceding calendar year, unless the insurer or HMO is a member of a group comprised of one or more insurers or HMOs authorized and actually doing the

business of insurance in another state that requires that an audited financial report be filed on or before June 1 for the preceding year. Under proposed new §7.88(b)(1), the proposed new §7.88(d)(1) – (4) filing requirements take effect beginning with the annual reporting period ending December 31, 2010, except as otherwise specified in §7.88 and in the Insurance Code Chapter 401, Subchapter A. As discussed previously, certain insurers or HMOs that are granted exemptions under the Insurance Code §401.006 or §401.008 would not be subject to proposed new §7.88(d)(1) – (4). The Department anticipates that many insurers or HMOs subject to proposed new §7.88(d)(1) – (4) will be required to file their audited financial reports on or before June 1 for the preceding calendar year, beginning with the annual reporting period ending December 31, 2010, pursuant to proposed new §7.88(b)(1) and (d)(1). It is the Department's understanding that the June 1 filing date in proposed new §7.88(d)(1) is consistent with the filing requirements of most, if not all, other states. Accordingly, the Department does not anticipate there will be any additional cost of compliance with proposed new §7.88(d)(1) for insurers or HMOs that are authorized to conduct the business of insurance in other states. Also, the Department anticipates that some insurers or HMOs may qualify for the limited exception to proposed new §7.88(d)(1) in proposed new §7.88(d)(2), because these insurers or HMOs, along with any affiliated insurers or HMOs, are licensed in and do business only in Texas. Insurers and HMOs that qualify for the limited exception to proposed new §7.88(d)(1) in proposed new §7.88(d)(2) are authorized to file their audited financial reports on or before June 30 for the

preceding year. The Department does not anticipate there will be any additional cost of compliance for insurers or HMOs that meet the limited exception because the proposed June 30 filing date in proposed new §7.88(d)(2) is the same as the filing date under current Texas statutory requirements. Additionally, the Department anticipates that some insurers or HMOs might be authorized in and doing business in Texas only, but are affiliated with insurers or HMOs that do business in other states and are required by those other states to file their audited financial reports on or before June 1. The Department does not anticipate there will be any additional cost of compliance for most of these insurers or HMOs because the proposed June 1 filing date in proposed new §7.88(d)(1) represents the current standard industry practice for preparing and filing audited financial reports in most, if not all, other states. Moreover, the Department anticipates that an insurer or HMO, that while authorized in and doing business in Texas only but which is affiliated with insurers or HMOs that do business in other states, will typically undergo an independent audit that concludes before the June 1 filing requirement of the other states. Nevertheless, the Department anticipates that a relatively small number of Texas domestic insurers or HMOs that are authorized in and doing business only in Texas, but are affiliated with insurers or HMOs that do business in other states, potentially may experience an increase in costs due to the June 1 filing date specified under proposed new §7.88(d)(1). The Department anticipates that these increased costs will typically result from an insurer or HMO using a smaller or regional accounting firm that, because of a smaller number of staff resources, may be

required to pay its staff overtime, or otherwise re-allocate its staff resources, in a manner that results in the firm charging higher costs to complete all of the audits for each member of the group by the June 1 filing date. The Department anticipates that this cost increase for these relatively few Texas domestic insurers or HMOs may vary substantially based upon a number of factors, including (i) the size, complexity, and sophistication of the insurer or HMO; (ii) the adequacy of the insurer's or HMO's accounting systems; and (iii) the size and availability of the staff resources of the accounting firm to be utilized. Each insurer or HMO that is authorized in and doing business only in Texas, but which is affiliated with insurers or HMOs that do business in other states that require these affiliated insurers or HMOs to file the audited financial reports on or before June 1, may contact its accounting firm to obtain an estimated cost for completing the audit by the June 1 filing date based upon the insurer's or HMO's particular operations. Moreover, proposed new §7.88(d)(4) provides that a carrier may elect to seek an extension of the filing date for the audited financial report in accordance with the Insurance Code §401.004(c). Section 401.004(c) authorizes the Commissioner to grant a written extension request for good cause based on a showing by the insurer or HMO or the insurer's or HMO's accountant of the reasons for requesting the extension. The Department has considered and granted extension requests submitted in accordance with the requirements in §401.004(c) in the past and anticipates continuing to do so in the future when appropriate. Therefore, an insurer or HMO has the option under the proposal of either complying with the June 1 filing date or seeking an extension of the filing

date under proposed §7.88(d)(4) and §401.004(c). In the event an insurer or HMO elects to seek an extension, the insurer or HMO would incur minor costs associated with the preparation and mailing of the extension request. However, because the extension request described under proposed new §7.88(d)(4) is the same as the extension request under §401.004(c) of the Insurance Code, any costs incurred for the extension request result from the enactment of the Insurance Code §401.004(c), and are not a result of the adoption, enforcement, or administration of proposed §7.88(d)(4). Additionally, proposed new §7.88(d)(3) restates the Insurance Code §401.004(b), which authorizes the Commissioner to require the filing of an audited financial statement on a date that precedes June 30 (i.e., before the June 1 deadline in proposed new §7.88(d)(1) or the June 30 deadline in proposed new §7.88(d)(2)).

Proposed New §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), (k), and (n)(1) Requirements for Non-Exempt Insurers or HMOs. Proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), (k), and (n)(1) address new audit committee requirements for certain insurers or HMOs that are not completely exempt from the proposed new §7.88 requirements pursuant to the Insurance Code §401.006 or §401.008, or under §401.007 and proposed new §7.88(e)(1). The proposed rules specify the types of non-exempt insurers or HMOs that are required to comply with the proposed audit committee requirements, the required membership of the audit committee, the requisite procedures for setting up the audit committee, and the functions of the audit committee. All of these factors relate to the estimated costs of persons required to comply with the proposed

requirements. Proposed new §7.88(b)(3) and (k) enumerate specific audit committee requirements that take effect August 1, 2010, for insurers or HMOs to which the Insurance Code Chapter 401, Subchapter A, applies, unless otherwise exempt under proposed new §7.88(k)(1) or (4). Proposed new §7.88(k)(1) exempts the following types of insurers or HMOs from the proposed new §7.88(k)(2) and (4) – (12) audit committee requirements: (i) a foreign or alien insurer or HMO; (ii) an insurer or HMO that is a SOX-compliant entity as defined in proposed new §7.88(c)(13); (iii) an insurer or HMO that is a direct or indirect wholly owned subsidiary of a SOX-compliant entity; or (iv) a non-stock insurer that is under the direct or indirect control of a SOX-compliant entity, including pursuant to the terms of an exclusive management contract. Proposed new §7.88(k)(4) allows a non-exempt insurer or HMO with premium of less than $500 million in direct written and assumed premiums (subject to certain exclusions in determining the amount of direct written and assumed premiums specified in §7.88(k)(4) and (5)) to apply to the Commissioner for a hardship waiver from the independence requirements of proposed new §7.88(k)(1), (2), and (5) – (12). If the Commissioner approves a waiver under proposed new §7.88(k)(4), the insurer or HMO is required to file, with its annual statement filing, the approval of the waiver with the states in which it does business or is authorized to do business and with the NAIC. Proposed new §7.88(c)(3) defines the term "audit committee" as a committee established by the board of directors of an entity for the purpose of overseeing (i) the accounting and financial reporting processes of an insurer or HMO or group of insurers or HMOs; and (ii) the audits of financial

statements of the insurer or HMO or group of insurers or HMOs. Under proposed new §7.88(c)(3), (d)(5), and (h)(7) – (9), all non-exempt insurers or HMOs are required to have an audit committee charged with the appointment, compensation, and supervision of the insurer or HMO's independent accountant. Furthermore, as provided under proposed new §7.88(k)(1), (2)(A) and (B), and (5), those non-exempt insurers or HMOs that are required to comply with the new audit committee independence requirements in proposed new §7.88(k)(2)(A) or (B) are mostly non-public Texas domestic insurers or HMOs with a combined total of $300 million or more in their preceding calendar year direct written and assumed premiums from non-affiliates for the reporting entities. Proposed new §7.88(k)(2)(A) requires a non-exempt insurer or HMO with over $500 million in direct written and assumed premiums for the preceding calendar year to establish an audit committee with an independent membership of at least 75 percent. Proposed new §7.88(k)(2)(B) requires a non-exempt insurer or HMO with $300 million to $500 million in direct written and assumed premiums for the preceding calendar year to establish an audit committee with an independent membership of at least 50 percent. Proposed new §7.88(k)(2)(C) provides that except as provided in §7.88(k)(3), a non-exempt insurer or HMO with less than $300 million in direct and assumed premiums for the preceding calendar year is not required to comply with the §7.88(k)(2) independence requirements for its audit committees. The insurers or HMOs subject to the proposed new §7.88(k)(3) requirement are those insurers and HMOs for which the Commissioner requires the insurer's or HMO's board to enact improvements to

the independence of the audit committee membership if the insurer or HMO (i) is in a risk-based capital action level event; (ii) meets one or more of the standards of an insurer or HMO considered to be in hazardous financial condition; or (iii) otherwise exhibits qualities of a troubled insurer or HMO. Proposed new §7.88(n)(1) addresses the transition dates for certain insurers or HMOs whose audit committee becomes subject to the independence requirements in proposed new 7.88(k) after August 1, 2010, because the total written and assumed premium exceeds the premium thresholds in §7.88(k)(2)(A) or (B) after August 1, 2010. Proposed new §7.88(k)(6) specifies certain responsibilities of insurer or HMO audit committees that relate to the independent accountant for the non-exempt insurer or HMO.

The Department anticipates that the majority of insurers or HMOs subject to the audit committee requirements in proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), (k), or (n)(1) typically either already utilize an audit committee, or carry out audit committee functions at the board of directors level, in order to comply with state or federal laws. In either case, the Department does not anticipate that additional costs will be incurred to initially set up the audit committee structure. Further, the Department anticipates that most prudently operated insurers or HMOs already utilize audit committees or utilize their board of directors in a manner consistent with the audit committee requirements specified in this proposal, either to comply with federal or state laws, or to comport with prudent best practices for corporate governance. For example, the Department anticipates that most, if not all, publicly-traded insurers or HMOs are

subject to SOX requirements, which are significantly similar to the audit committee requirements in proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), (k), and (n)(1). Therefore, the Department does not expect SOX-compliant insurers or HMOs to incur any additional costs to comply with these proposed audit committee requirements. Also, the Department anticipates that, in order to comply with the Texas Insurance Code or the laws of other states, a large percentage of public and non-public insurers or HMOs that are authorized in Texas currently have audit committees or boards of directors that carry out most, if not all, of the audit committee requirements specified in proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), (k), and (n)(1). For example, under the Insurance Code §401.017(a), an insurer or HMO required to file an audited financial report under Chapter 401, Subchapter A, must require its independent accountant to immediately notify the board of directors of the insurer or HMO or the insurer's or HMO's audit committee in writing of any determination by the independent accountant that: (i) the insurer or HMO has materially misstated the insurer's or HMO's financial condition as reported to the Commissioner as of the balance sheet date being audited; or (ii) the insurer or HMO does not meet minimum capital and surplus requirements prescribed in the Insurance Code for the insurer or HMO as of that date. Also, in order to comply with the current independent audit requirements in the Insurance Code Chapter 401, Subchapter A, the Department anticipates that an insurer or HMO that is required to file an audited financial report under Subchapter A will employ, compensate, and oversee the work of a statutorily qualified accountant, including that the

accountant is independent, qualified, and otherwise compliant with the requirements in §§401.011 – 401.013 of the Insurance Code. Moreover, the Department anticipates that an insurer or HMO will comply with the proposed audit committee requirements in the most efficient manner, and thus, avoid or minimize compliance costs. For example, the Department anticipates that certain insurers or HMOs that currently elect to have their entire board of directors perform the audit committee functions simply will continue to elect to have their entire board retain these functions pursuant to proposed new §7.88(c)(3), and (d)(5). Also, in accordance with proposed new §7.88(d)(5), the audit committee of the entity that controls a group of insurers or HMOs may, at the election of the controlling person, be the audit committee for one or more of the controlled insurers or HMOs. Use of this option can eliminate the costs to an insurer or HMO to establish another audit committee at the insurer or HMO level. Thus, an insurer or HMO has the discretion to implement an audit committee structure in the most cost effective manner.

The Department, however, expects that currently some non-public insurers or HMOs, including small or micro business insurers or HMOs, subject to the proposed audit committee requirements, do not utilize audit committees or their board or directors in a manner and method substantially similar, in whole or in part, to the manner and method required under proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), (k), and (n)(1). In these instances, the Department anticipates that some additional costs will be incurred by these insurers or HMOs to comply with these audit committee requirements. The Department anticipates

that the total probable compliance cost will vary substantially among insurers or HMOs. The actual cost to each insurer or HMO will depend on factors unique to each insurer or HMO, such as (i) the extent to which an insurer or HMO already has established and utilizes an audit committee or board or directors to carry out the audit committee functions contemplated in the proposal; (ii) whether an insurer or HMO has premium levels that meet or exceed the premium thresholds in proposed new §7.88(k)(2)(A) or (B) or, in accordance with proposed new §7.88(n)(1), has premium levels that make the insurer or HMO subject to the audit committee independence requirements after August 1, 2010; (iii) whether an insurer or HMO applies for and is granted a waiver of the audit committee independence requirements based on hardship under proposed new §7.88(k)(4); and (iv) whether an insurer or HMO is operating in a hazardous financial condition or risk based capital action level. Those insurers or HMOs that have already established and utilize an audit committee or board of directors to carry out the audit committee functions will likely incur no additional compliance costs. Those that do not currently utilize such an audit committee will incur certain additional compliance costs. At a minimum, an insurer or HMO may need to develop and implement an audit committee approval process to review and approve independent accountant appointments and compensation packages, and to oversee the independent accountant's work, as contemplated under proposed new §7.88(c)(3) and (k). Also, at a minimum, an insurer or HMO may need to develop an audit committee approval process to review and approve audit and non-audit services that an independent accountant is authorized to

provide to the insurer or HMO in accordance with proposed new §7.88(h)(7) – (9). Additionally, to the extent an insurer's or HMO's audit committee or board of directors is not already performing the audit committee functions required under proposed new §7.88(c)(3), (h)(7) – (9), and (k), the insurer or HMO may incur some additional audit related compliance costs. These additional costs would primarily be for compensation of audit committee members to perform new auditing related functions. Further, the Department anticipates that, unless exempted under proposed new §7.88(k)(4), a small number of large non-public insurers or HMOs will be required under proposed new §7.88(b)(3), (k)(2), and (n)(1) to add and retain an independent member or members to their board of directors and audit committees effective beginning August 1, 2010, and annually thereafter. The costs for such addition and retention of independent members, however, will also depend on the insurer's or HMO's annual total direct written and assumed premiums for the preceding calendar year as provided in §7.88(k)(2)(A) or (B). Proposed new §7.88(k)(8) provides that to be independent for purposes of §7.88(k), a member of the audit committee may not, other than in the person's capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory, or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary of the entity. Proposed new §7.88(k)(5) further provides that to the extent of any conflict with a statute requiring an otherwise non-independent board member to participate in the audit committee, the other statute prevails and controls, and the member may participate in the audit committee unless the

member is an officer or employee of the insurer or HMO or an affiliate of the insurer or HMO. The small number of large non-public insurers or HMOs will be expected to incur one-time expenses to recruit and evaluate the new member or members and annual costs to compensate this member or members to carry out the annual audit committee functions required under the proposal. The actual total costs to increase compensation to its current audit committee or board members or to retain a new independent audit committee member or members will vary substantially depending on such factors as (i) the size and type of the insurer; (ii) the location of its offices; (iii) the amount and complexity of its business; and (iv) the insurer's or HMO's particular business practices related to the compensation of directors, including the various types of compensation paid to directors, such as annual board member compensation, fees for attending board meetings, fees for serving on committees, and stock options. The Department anticipates that the compensation arrangements will vary substantially depending on such factors as (i) the size and complexity of the insurer's or HMO's operations; (ii) the scope and complexity of the duties assumed by the board member or audit committee member, (iii) whether the insurer or HMO employs certain business models specifically designed to reduce administrative costs, and (iv) whether a controlling person elects to have the audit committee of an entity that controls an insurer or HMO also be the audit committee for the insurer or HMO. The Department anticipates that these compensation practices will vary widely among insurers or HMOs. The actual cost to each insurer or HMO to increase compensation to existing board or audit

committee members or to retain a new independent audit committee member or members will depend on factors unique to each insurer or HMO. As a result of these numerous and varying factors, each insurer or HMO subject to the proposed audit committee requirements has the information necessary to estimate the actual compliance costs for that individual insurer or HMO. Moreover, the Department anticipates that the probable total costs of obtaining a new independent board member (or members) may be mitigated or offset in instances where a new independent board member (or members) is replacing an existing non-independent member (or members). In effect, the compensation costs that are saved by the removal from the board of non-independent member or members can be used to compensate the new independent member or members replacing the removed non-independent member or members. This may significantly offset the total compensation costs that would be incurred for the new independent member or members.

Additionally, certain insurers or HMOs subject to the proposed new §7.88(k)(2)(A) or (B) audit committee requirements have the option of complying with the independent audit requirements or electing to apply for a hardship waiver under proposed new §7.88(k)(4). Those insurers or HMOs that elect to apply for a waiver under proposed new §7.88(k)(4) will incur certain optional administrative costs in the preparation and submission of the waiver request. The Department anticipates that these elective costs will be nominal, typically less than $50 - $100. This estimated cost is based upon a member of an insurer’s or HMO’s management staff preparing the necessary information within

a one to two-hour period. The salary for this staffer is estimated at the mean salary rate of $53.95 per hour, as set forth for similar management positions in the latest State Occupational Employment and Wage Estimates for Texas (May 2008) published by the United States Department of Labor (DOL) at http//www.bls.gov/oes/current/oes_tx.htm. Proposed new §7.88(k)(4) also provides that an insurer or HMO that obtains a waiver from the Commissioner must file the approval of the waiver with the other states in which it does or is authorized to do business and with the NAIC. If a state other than Texas accepts electronic filings, the insurer or HMO is required to file the approval in an electronic format acceptable to the NAIC. Accordingly, an insurer or HMO would incur routine, optional administrative costs associated with filing copies of the approval in certain other states and with the NAIC. The Department anticipates that the total probable optional cost of preparing and submitting the information required under proposed new §7.88(k)(4) will vary but will typically be less than $100. This is based upon a member of an insurer's or HMO's administrative staff preparing the necessary information within a one to four-hour period. The salary for this staffer is estimated at the mean salary rate of $23.04 per hour, as set forth for similar office and administrative support positions in the latest DOL Wage Estimates report. The Department estimates that a member of the insurer's or HMO's management staff could review and approve the prepared information in less than 30 minutes. The salary for this staffer is estimated at the mean salary rate of $53.95 per hour, as set forth for similar management positions in the latest DOL Wage Estimates report. Additionally, proposed new

§7.88(k)(9) allows an audit committee member that ceases to be independent for reasons outside the member's control to remain an audit committee member for a certain specified time if the responsible entity gives notice to the Commissioner. Proposed new §7.88(k)(9) is not applicable to insurers or HMOs required to enact improvements to the independence of the audit committee membership under proposed new 7.88(k)(3). If an insurer or HMO elects to retain such an audit committee member or members, the ongoing costs for such a member(s) will continue to be incurred by the insurer or HMO and will be known to the insurer or HMO at the time that the decision is made to allow the member(s) to continue to serve.

Under proposed new §7.88(k)(10), the audit committee of an entity that controls an insurer or HMO may, at the election of the controlling person, be the insurer's or HMO's audit committee. In order for the controlling person to elect this option, proposed new §7.88(k)(10) requires the ultimate controlling person to provide a written notice of the affected insurers or HMOs with the Commissioner. The Department anticipates that these elective costs for the written notice will be nominal, typically less than \$50 - \$120. This estimated cost for the written notice is based upon a member of an insurer's or HMO's management staff preparing the necessary information within a one to two-hour period. The salary for this staffer is estimated at the mean salary rate of \$58.23 per hour, as set forth for similar management positions in the latest DOL Wage Estimates report.

<u>Proposed new §7.88(h)(1) – (5) and (10) - (12) Requirements for Non-Exempt Insurers or HMOs.</u> Proposed new §7.88(h)(1) – (5) and (10) – (12)

specify requirements for non-exempt insurers or HMOs concerning certain accountant qualifications and independence requirements for an independent accountant that prepares and files an audited financial report with the Commissioner pursuant to the Insurance Code Chapter 401, Subchapter A. A non-exempt insurer or HMO is an insurer or HMO that does not meet an exemption under the Insurance Code §401.006 or §401.008 or under §401.007 and proposed new §7.88(e)(1), except as otherwise provided under proposed new §7.88(h)(1), (6) or (10). The requirements in proposed new §7.88(h)(1) – (5) and (10) - (12) effectuate the independent accountant independence and qualifications requirements in the Insurance Code §§401.011 – 401.014. These requirements also implement and/or supplement the Insurance Code Chapters 404, 441, and 843, concerning an insurer's or HMO's hazardous financial condition.

An insurer or HMO that is subject to the proposed new §7.88(h)(1) – (2), (4) – (6), (10), and (12) requirements potentially may incur new or additional overall compliance costs, depending upon such factors as (i) whether and to what extent an insurer or HMO already has implemented these requirements voluntarily or to comply with the requirements in the SOX, the Insurance Code §401.011, or laws in other states in which the insurer or HMO is authorized to conduct business; and (ii) whether an insurer or HMO applies for and is granted one or more of the exemptions provided for under proposed new §7.88(h)(1), (6), and (10). Also, the total probable overall compliance costs for an insurer or HMO is expected to vary substantially based upon these same factors. Proposed new

§7.88(h)(1) prohibits a lead partner or other person responsible for rendering a report for an insurer or HMO from (i) acting in that capacity for more than five consecutive years; and (ii) during the five-year period after that fifth year, rendering a report for the insurer or HMO or for a subsidiary or affiliate of the insurer or HMO that is engaged in the business of insurance. Also, the Department anticipates that rather than complying with the requirements in proposed new §7.88(h)(1), (4), and (10), some insurers or HMOs may opt to apply for one or more of the exemptions provided under proposed new §7.88(h)(1), (6), or (10). The Department anticipates that small or micro business insurers and HMOs are more likely than larger business insurers and HMOs to qualify and be granted an exemption under proposed new §7.88(h)(1), (6), or (10) because of the criteria specified to qualify for the exemption.

Proposed new §7.88(h)(1) sets forth the rotation requirements for a new lead audit partner or other person responsible for rendering the audited financial report and allows an insurer or HMO to apply for an exemption to the requirements in accordance with proposed new §7.88(h)(1) and (2). Proposed new §7.88(h)(1) provides that on application made at least 30 days before the end of the calendar year, the Commissioner may determine that the requirement in this paragraph does not apply to the independent accountant for a particular insurer or HMO if the insurer or HMO demonstrates to the satisfaction of the Commissioner that the application of the requirement to the insurer or HMO would be unfair because of unusual circumstances. Proposed new §7.88(h)(1)(A) – (C) specify the following factors the Commissioner may consider

in making this determination: (i) the number of partners or individuals the accountant employs, the expertise of the partners or individuals the accountant employs, or the number of the accountant's insurance clients; (ii) the premium volume of the insurer or HMO; and (iii) the number of jurisdictions in which the insurer or HMO engages in business.

The Department anticipates that insurers or HMOs, particularly small and micro business insurers or HMOs, that otherwise may incur significant new or additional costs to rotate a lead partner or other person responsible for rendering an audited financial report or the hiring of a new accounting firm every five years as required under proposed new §7.88(h)(1), may elect to apply for an exemption under proposed new §7.88(h)(1). Based on the criteria for an exemption from the requirement in §7.88(h)(1), the cost to comply with the five-year rotation requirement would be considered by the Commissioner in determining whether to grant an exemption. Because the proposed new §7.88(h)(1) requirements are similar to requirements set forth in SOX and regulations adopted thereunder by the Securities and Exchange Commission, the Department anticipates that the majority of publicly-traded insurers or HMOs already may have implemented these requirements in order to comply with the similar SOX requirements. The Department anticipates, however, that some mostly non-public insurers or HMOs that do not qualify or that do not apply for an exemption under proposed new §7.88(h)(1) will need to rotate their lead partner or other qualified person or replace their existing lead independent accounting firm for the audit to comply with the proposed new §7.88(h)(1) five-year rotation requirement. This will be

necessary for the preparation and filing of the audited financial reports beginning with the report for calendar year 2010. However, proposed new §7.88(h)(1) does not require that an entire independent accounting firm be rotated every five years. Rather, proposed new §7.88(h)(1) requires that a lead partner or other person responsible for the audit be rotated every five years. This may necessitate in some instances the hiring of a new independent accounting firm. In the majority of cases, however, the Department anticipates that most independent accounting firms will have a sufficient number of lead partners or other qualified persons to be able to simply rotate one of the existing independent accounting firms' lead partners or other qualified persons and replace them with another from the same firm. The new lead partner or other qualified person may need to familiarize himself or herself with the insurer's or HMO's business operations, accounting practices, procedures and systems, and financial condition. This may result in an insurer or HMO incurring new or additional costs to compensate the existing independent accounting firm for any additional work the new lead partner or other qualified person performs to ensure that there is appropriate knowledge transfer. An insurer or HMO that needs to replace its existing independent accounting firm with a new independent accounting firm in order to meet the proposed new §7.88(h)(1) requirements also may incur new or additional costs. Again, these costs will be primarily for the new independent accounting firm to familiarize itself with the insurer's or HMO's operations, financial records and condition, and accounting records and systems. The total probable new or additional costs for an insurer or HMO to rotate a lead

partner or other qualified person or replace its existing independent accounting firm with a new independent accounting firm will vary substantially depending on such factors as (i) past and existing accounting or financial irregularities, deficiencies, weaknesses, exceptions, or unique practices; (ii) the complexity of the insurer's or HMO's business; (iii) the sophistication, reliability, and adequacy of its financial reporting processes, internal controls, accounting systems; and (iv) the qualifications and experience of the insurer's or HMO's staff. However, there are mitigating cost factors. First, after the existing lead partner is rotated out or the existing independent accounting firm is replaced, the insurer or HMO will no longer incur the costs associated with the outgoing lead partner or outgoing independent accounting firm. This reduction in prior costs will mitigate or offset the costs associated with engaging the new incoming lead partner or new incoming independent accounting firm. Therefore, the Department anticipates that at the end of the familiarization period, an insurer or HMO may realize a significant offset in terms of compensation costs. Second, the Department anticipates that most of these new or additional costs will be incurred in preparing and submitting the new partner's or new independent accounting firm's first audited financial report for the insurer or HMO, and that such costs will be reduced in future years. These reduced costs will result from the ability of the new partner or other person rendering the audit or new independent accounting firm to prepare the audited financial reports more efficiently and in a shorter time period due to greater knowledge of and familiarity with the insurer or HMO being audited. This, in turn, will result in the insurer or HMO incurring less

compensation costs for the independent accounting firm in subsequent years. The greater knowledge and familiarity will relate to the insurer or HMO's method of operations, including internal control framework, accounting systems, and policies and procedures. Based on the foregoing analysis, insurers and HMOs either have the necessary cost information or have access to the necessary cost information to determine the potential compliance costs for proposed §7.88(h)(1).

An insurer or HMO that obtains the Commissioner's approval for an exemption under proposed new §7.88(h)(1) must, pursuant to proposed §7.88(h)(2), file the approval with the states in which it is doing or is authorized to do business and with the NAIC. If a state other than Texas accepts electronic filing with the NAIC, the insurer or HMO must file the approval in an electronic format acceptable to the NAIC. The Department estimates that the total cost of applying for the §7.88(h)(1) exemption and to file the §7.88(h)(2) exemption approval will likely range from approximately $100 to $280. This estimate is based on the following factors. An insurer or HMO electing to apply for the §7.88(h)(1) exemption may incur nominal costs in making this application, typically less than $50 - $150. This estimate is based upon a member of an insurer's or HMO's management staff preparing the necessary information in one - three hours. The salary for this staffer is estimated at the mean salary rate of $53.95 per hour, as set forth for similar management positions in the latest State Occupational Employment and Wage Estimates for Texas published by the DOL (May 2008). The Department anticipates that the total probable cost of preparing and submitting the information required under proposed new §7.88(h)(2) will vary

but will typically be less than $100. This estimate is based upon a member of an insurer's or HMO's administrative staff preparing the necessary information in between one – four hours. The salary for this staffer is estimated at the mean salary rate of $23.04 per hour, as set forth for similar office and administrative support positions in the latest State Occupational Employment and Wage Estimates for Texas published by the DOL (May 2008). Additionally, the Department estimates that a member of the insurer's or HMO's management staff could review and approve the prepared information in less than 30 minutes. The salary for this staffer is estimated at the mean salary rate of $53.95 per hour, as set forth for similar management positions in the latest State Occupational Employment and Wage Estimates for Texas published by the DOL (May 2008).

Proposed new §7.88(h)(3)(A) and (B) specify the services that the independent accountant that renders the audited financial report pursuant to §7.88(h)(1) is prohibited from providing. Under proposed new §7.88(h)(3)(A), the independent accountant is prohibited from (i) functioning in the role of management, (ii) auditing the independent accountant's own work, or (iii) serving in an advocacy role for the insurer or HMO. The proposed new §7.88(h)(3)(A) requirements are not expected to result in any new or additional requirements for any insurer or HMO subject to proposed new §7.88(h)(3)(A). Therefore, the Department does not anticipate that insurers or HMOs will incur any new or additional costs as a result of the §7.88(h)(3)(A) prohibitions. Proposed new §7.88(h)(3)(B) restates the existing independent accountant independence and qualification requirement in the Insurance Code

§401.011(d)(4). Section §7.88(h)(3)(B) prohibits the independent accountant that renders the audited financial report from directly or indirectly entering into an agreement of indemnity or release from liability regarding the audit of the insurer or HMO. Any costs to comply with these restated requirements are the result of the enactment of the Insurance Code §401.011(d), and are not a result of the adoption, enforcement, or administration of this proposal.

Proposed new §7.88(h)(4) provides that the Commissioner may not recognize as qualified or independent an accountant, or accept an annual audited financial report that was prepared wholly or partly by an accountant, who provides certain specified non-audit services to an insurer or HMO at the time of the audit. Proposed new §7.88(h)(5) provides that notwithstanding proposed new §7.88(4)(D), an independent accountant and the independent accountant's actuary, under certain specified conditions, may provide certain actuarially oriented advisory services involving the determination of amounts recorded in the financial statements. Proposed new §7.88(h)(6) allows certain insurers and HMOs with direct written and assumed premiums of less than $100 million in any calendar year to apply for an exemption to the proposed §7.88(h)(4) prohibitions relating to the types of services or functions that the independent accountant is not allowed to provide to the insurer or HMO. Such insurers and HMOs may request an exemption from the requirements of proposed new §7.88(h)(4) by filing with the Commissioner a written statement explaining why the insurer or HMO should be exempt. Proposed new §7.88(h)(6) provides that the Commissioner may grant the exemption if the Commissioner finds that

compliance would impose an undue financial or organizational hardship on the insurer or HMO. Therefore, an insurer or HMO has the option under the proposal of either utilizing an independent accountant that complies with the required qualifications and independence requirements in proposed new §7.88(h)(4) or applying for an exemption under proposed new §7.88(h)(6). In the event an insurer or HMO elects to seek an exemption, the insurer or HMO would incur costs associated with the preparation and mailing of the application for the exemption. The Department anticipates that these costs would be minimal and would typically range from approximately $50 to $150. This estimate is based upon a member of an insurer's or HMO's management staff preparing the necessary application in one - three hours. The salary for this staffer is estimated at the mean salary rate of $53.95 per hour, as set forth for similar management positions in the latest State Occupational Employment and Wage Estimates for Texas published by the DOL (May 2008).

Proposed new §7.88(h)(10) prohibits the Commissioner from recognizing as qualified or independent, an accountant for a particular insurer or HMO if a member of the board, the president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for the insurer or HMO, was employed by the accountant and participated in the audit of that insurer or HMO during the one-year period preceding the date on which the most current statutory opinion is due. This proposed prohibition would apply only to partners and senior managers involved in the audit. Under proposed new §7.88(h)(10), an insurer or HMO may apply to

the Commissioner for an exemption from the §7.88(h)(10) requirements on the basis of unusual circumstances. An insurer or HMO thus has the option of either utilizing an independent accountant that complies with the required qualifications and independence requirements of proposed new §7.88(h)(10) or electing to apply for an exemption. In the event an insurer or HMO elects to seek an exemption, the insurer or HMO would incur costs associated with the preparation and mailing of the application for the exemption. The Department anticipates that these costs would be minimal and would typically range from approximately $50 to $150. This estimate is based upon a member of an insurer's or HMO's management staff preparing the necessary application in one – three hours. The salary for this staffer is estimated at the mean salary rate of $53.95 per hour, as set forth for similar management positions in the latest State Occupational Employment and Wage Estimates for Texas published by the DOL (May 2008).

The Department anticipates that insurers or HMOs, particularly small and micro business insurers or HMOs, that otherwise may incur significant new or additional costs to replace their existing independent accounting firm in order to comply with the requirements in proposed new §7.88(h)(4) or (10), may elect to apply for an exemption under proposed new §7.88(h)(6) or (10). Such significant costs would result from any additional compensation needed by the new independent accounting firm to familiarize itself with the insurer's or HMO's operations, financial records and condition, and accounting records and systems. Based on the criteria for an exemption from the requirement in §7.88(h)(4) of having to find a replacement independent accounting firm, the cost of compliance

with such requirements would be considered by the Commissioner in determining whether to grant an exemption. Because the proposed §7.88(4) and (10) requirements are similar to requirements set forth in SOX and regulations adopted thereunder by the SEC, the Department anticipates that the majority of publicly-traded insurers or HMOs already may have implemented these requirements in order to comply with the similar SOX requirements. The Department anticipates, however, that some mostly non-public insurers or HMOs that do not qualify or that do not apply for an exemption under proposed new §7.88(h)(6) will need to: (i) replace their existing lead independent accounting firm for the preparation and filing of the insurers' or HMOs' required audited financial reports; or (ii) continue using their existing lead independent accounting firm for the audit but stop receiving any services from the independent accounting firm that are prohibited under proposed §7.88(h)(4) if that accounting firm is going to prepare the audited financial reports for the insurers or HMOs beginning with the report covering calendar year 2010. Additionally, the Department anticipates that some mostly non-public insurers or HMOs that do not qualify or that do not apply for an exemption under proposed new §7.88(h)(10) will need to replace their existing lead independent accounting firm to prepare and file the insurers' and HMOs' audited financial reports beginning with the report for calendar year 2010 in order to comply with proposed new §7.88(h)(10). In certain instances, the Department anticipates that some insurers or HMOs required to find a replacement independent accounting firm will incur new or additional costs to comply with proposed new §7.88(4) or (10). These

costs will be primarily for the new independent accounting firm to familiarize itself with the insurer's or HMO's operations, financial records and condition, and accounting records and systems. The total probable new or additional costs for each insurer or HMO replacing its existing independent accounting firm with a new independent accounting firm will vary substantially depending on such factors as (i) past and existing accounting or financial irregularities, deficiencies, weaknesses, exceptions, or unique practices; (ii) the complexity of the insurer's or HMO's business; (iii) the sophistication, reliability, and adequacy of its financial reporting processes, internal controls, accounting systems; and (iv) the qualifications and experience of the insurer's or HMO's staff. However, there are also mitigating cost factors. First, after the existing independent accounting firm is replaced, the insurer or HMO will no longer incur the costs associated with the independent firm that is being replaced. This reduction in prior costs will mitigate or offset the costs associated with engaging the new independent accounting firm. Therefore, the Department anticipates that at the end of the familiarization period, an insurer or HMO will realize a significant offset in terms of compensation costs. Second, the Department anticipates that most of these new or additional costs will be incurred in preparing and submitting the new independent accounting firm's first audited financial report for the insurer or HMO, and that such costs will be reduced in future years. These reduced costs will result from the ability of the independent accounting firm to prepare the audited financial reports more efficiently and in a shorter time period due to the firm's greater knowledge of and familiarity with the insurer or HMO being audited.

This, in turn, will result in the insurer or HMO incurring less compensation costs for the independent accounting firm in subsequent years. The greater knowledge and familiarity will relate to the insurer or HMO's method of operations, including internal control framework, accounting systems, and policies and procedures. Based on the foregoing analysis, insurers or HMOs either have the necessary cost information or have access to the necessary cost information to determine the potential compliance costs for proposed §7.88(4) and (10).

Additionally, in certain instances, the Department anticipates that some insurers or HMOs that comply with proposed §7.88(h)(4), and thereby cease receiving services that are prohibited under §7.88(h)(4) from their existing independent accounting firm, may incur new or additional costs from engaging a new accounting firm or hiring additional staff to provide the services that the independent accounting firm that prepares the audited financial report can no longer provide. Also, the Department anticipates that possibly, though infrequently, the insurer or HMO may be charged higher fees by the existing independent accounting firm to continue to provide the insurer or HMO with only those services that are related to the preparation of the audited financial report. This could be the result in those instances in which the existing independent accounting firm provided a discount for providing a group of several accounting related services. The new independent accounting firm also may charge the insurer or HMO higher fees, at least initially, than the existing independent accounting firm charged for providing the services that the existing independent accounting firm that prepares the audited financial report is prohibited from

providing under proposed new §7.88(h)(4). These additional fees will be primarily to compensate the new accounting firm for the extra time and work needed to familiarize itself with the insurer's or HMO's operations, financial records and condition, and accounting records and systems. The total probable new or additional costs for each insurer or HMO replacing its existing independent accounting firm with a new accounting firm will vary substantially depending on such factors as (i) the size of the insurer or HMO in terms of premium volume or policies in force; (ii) the complexity of the insurer's or HMO's business; (iii) the sophistication, reliability, and adequacy of its financial reporting processes, internal controls, accounting systems; (iv) past and existing accounting or financial irregularities, deficiencies, weaknesses, exceptions, or unique practices; (v) the qualifications and experience of the insurer's or HMO's staff; and (vi) the types and complexities of the services being provided. However, again, there are mitigating cost factors. First, after the existing independent accounting firm is replaced, the insurer or HMO will no longer incur the costs associated with the outgoing independent accounting firm; this reduction in prior costs will mitigate or offset the costs associated with engaging the new incoming accounting firm. Therefore, the Department anticipates that at the end of the familiarization period, an insurer or HMO will realize a significant offset in terms of compensation costs. Second, the Department anticipates that most of these new or additional costs will be incurred in the first year that the new accounting firm provides the new services for the insurer or HMO, and that such costs will be reduced in future years. These reduced costs will result from an

enhanced familiarity with the insurer or HMO being provided the new services, including its method of operations, internal control framework, accounting systems, and policies and procedures in subsequent years as this familiarity and knowledge is applied to future services.

Proposed new §7.88(h)(11) restates the existing independent accountant independence and qualification requirements in the Insurance Code §401.011(d)(1) - (3). It prohibits the Commissioner from accepting an audited financial report prepared wholly or partly by an individual or firm that the Commissioner finds: (i) has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act (18 U.S.C. Section 1961 et seq.), or a state or federal criminal offense involving dishonest conduct; (ii) has violated the insurance laws of this state with respect to a report filed under the Insurance Code Chapter 401, Subchapter A, or this section; (iii) has demonstrated a pattern or practice of failing to detect or disclose material information in reports filed under the Insurance Code Chapter 401, Subchapter A, or this section; or (iv) has directly or indirectly entered into an agreement of indemnity or release of liability regarding an audit of an insurer. Any costs to comply with these restated requirements are the result of the enactment of the Insurance Code §401.011(d), and are not a result of the adoption, enforcement, or administration of this proposal.

Proposed new §7.88(h)(12) requires an insurer or HMO that obtains the Commissioner's approval for an exemption under proposed new §7.88(h)(6) or (10) to file the approval with the states in which it is doing or is authorized to do

business and with the NAIC. If a state other than Texas accepts electronic filing with the NAIC, the insurer or HMO must file the approval in an electronic format acceptable to the NAIC. The Department anticipates that the total probable cost of preparing the information required under proposed new §7.88(h)(12) will vary but will typically be less than $100. This is based upon a member of an insurer's or HMO's administrative staff preparing the necessary information in one – four hours. The salary for this staffer is estimated at the mean salary rate of $23.04 per hour, as set forth for similar office and administrative support positions in the latest State Occupational Employment and Wage Estimates for Texas published by the DOL (May 2008). Additionally, the Department estimates that a member of the insurer's or HMO's management staff could review and approve the prepared information in less than 30 minutes. The salary for this staffer is estimated at the mean salary rate of $53.95 per hour, as set forth for similar management positions in the DOL May 2008 Texas Wage Estimates. The cost for actually submitting the prepared information to the states in which the insurer or HMO is doing or is authorized to do business and with the NAIC will be minimal because most such filings will be done electronically.

Proposed new §7.88(j) Requirements for Non-Exempt Insurers or HMOs. Proposed new §7.88(j) specifies the requirements applicable to non-exempt insurers or HMOs for preparing and filing the communication of internal control matters noted in the audit. A non-exempt insurer or HMO is an insurer or HMO that does not meet an exemption under the Insurance Code §401.006 or §401.008, or under §401.007 and proposed new §7.88(e)(1). The

communication of internal control matters noted in the audit is in addition to the audited financial report required by Chapter 401, Subchapter A, of the Insurance Code and this proposal. Proposed new §7.88(j)(1) requires each non-exempt insurer or HMO to provide annually to the Commissioner a written communication prepared by an independent accountant that includes a description of any un-remediated material weaknesses in its internal controls over financial reporting noted during the audit. The communication must be prepared by an independent accountant in accordance with the Professional Standards of the American Institute of Certified Public Accountants. Additionally, the communication must contain a description of any un-remediated material weaknesses, as defined by Statement on Auditing Standards No. 112, "Communicating Internal Control Related Matters Identified in an Audit," or a successor document. As required in proposed new §7.88(j)(2), the non-exempt insurer or HMO must also provide a description of remedial actions taken or proposed to be taken to correct un-remediated material weaknesses, if the actions are not described in the independent accountant's communication. The information required to be filed under the Insurance Code §401.019 has been updated in proposed new §7.88(j) to conform to the updated generally accepted auditing standards, as required in the NAIC Model Audit Rule. Section 401.019 provides that in addition to the audited financial report required by the Insurance Code Chapter 401, Subchapter A, each insurer or HMO shall (i) provide to the Commissioner a written report of significant deficiencies required and prepared by an independent accountant in accordance with the Professional Standards of

the American Institute of Certified Public Accountants; (ii) annually file the report not later than the 60th day after the date the audited financial report is filed; and (iii) also provide a description of remedial actions taken or proposed to be taken to correct significant deficiencies, if the actions are not described in the independent accountant's report. Section 401.019 further requires that the report follow generally the form for communication of internal control structure matters noted in an audit described in Statement on Auditing Standard (SAS) No. 60, AU Section 325, Professional Standards of the American Institute of Certified Public Accountants. The Statement on Auditing Standard No. 60 has been superseded by Statement on Auditing Standard No. 112. The reporting required under proposed new §7.88(j) is consistent with the new Statement on Auditing Standard No. 112. Additionally, the Insurance Code §401.013(a)(3)(B) requires the independent accountant to provide a letter stating that the independent accountant conforms to the standards of the profession contained in the American Institute of Certified Public Accountants Code of Professional Conduct, the statements of the institute, and the rules of professional conduct adopted by the Texas State Board of Public Accountancy, or a similar code. Thus, an independent accountant is expected to conform to SAS No. 112, as contemplated under §401.013(a)(3)(B), which parallels the requirement under proposed §7.88(j)(1). As a result, proposed new §7.88(j) does not impose any new or additional requirements to those provided under the Insurance Code §401.013(a)(3)(B) and §401.019, and, therefore, is not expected to result in any compliance costs that are in addition to those costs incurred by a non-exempt

insurer or HMO to meet the current reporting requirements in §401.013(a)(3)(B) and 401.019 of the Insurance Code.

Proposed New §7.88(m) and (n)(2) Requirements. The primary purpose of proposed new §7.88(m) and (n)(2) is to specify the content and procedural requirements and exemptions and limitations relating to the preparation and filing of a report on internal control over financial reporting with the Commissioner on an annual basis. Because the compliance costs related to the various provisions of proposed §7.88(m) are closely intertwined, it is necessary to discuss these estimated costs and related cost factors together for several of the related provisions.

The term *internal control over financial reporting* that is required in proposed §7.88(m)(1) and (2) is defined in proposed new §7.88(c)(8) as "A process implemented by an entity's board of directors, management, and other personnel designed to provide reasonable assurance regarding the reliability of the entity's financial statements. The term includes policies and procedures that: (A) relate to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets; (B) provide reasonable assurance that: (i) transactions are recorded as necessary to permit preparation of the financial statements; and (ii) receipts and expenditures are made only in accordance with authorizations of management and directors; and (C) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of assets that could have a material effect on the financial statements." The internal control over financial reporting

requirements in proposed new §7.88(m) are effective beginning with the reporting period ending December 31, 2010, which period is reflected in reports and communications required to be filed with the Commissioner during calendar year 2011, and continues in effect each year thereafter. Also, proposed new §7.88(n)(2) sets forth transitional periods for compliance with proposed new §7.88(m) for certain insurers or HMOs or groups of insurers or HMOs. Specifically, proposed new §7.88(n)(2) requires an insurer or HMO or group of insurers or HMOs that is not required by proposed new §7.88(m)(1) to file a report beginning with the reporting period ending December 31, 2010, because the total written premium is below the required threshold amount, to file a report no later than two years after the year in which the written premium exceeds the required threshold amount to file a report.

Under proposed new §7.88(m)(1), the management of an insurer or HMO is required to prepare an annual management report of the insurer's or HMO's internal control over financial reporting and submit that report annually to the Commissioner. The insurers or HMOs required to file this report are: (i) as provided in proposed §7.88(m)(1), certain large insurers and HMOs required to file an audited financial report under the Insurance Code Chapter 401, Subchapter A, and proposed new §7.88; these insurers or HMOs are insurers and HMOs that have $500 million or more in annual written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, and that do not meet an exemption provided under §401.006 or §401.008, or under §401.007 and

proposed new §7.88(e)(2); and (ii) as provided in proposed new §7.88(m)(2), other insurers or HMOs of any premium volume size that may be required by the Commissioner to file the report because the insurer or HMO is in any risk-based capital level event or meets one or more of the standards of an insurer or HMO considered to be in hazardous financial condition as described by and provided in the Insurance Code Chapters 404, 441, 822, 841, 843, or 884 or rules adopted thereunder, including §7.402 (relating to Corporate and Financial Regulation), §§8.1 - 8.4 (relating to Early Warning System for Insurers in Hazardous Condition), and §11.810 (relating to Hazardous Conditions for HMOs). The Department anticipates that the potential costs associated with proposed new §7.88(m)(1) primarily will impact a relatively small number of large, non-public insurers and HMOs because: (i) primarily only large insurers and HMOs with $500 million or more in annual direct and assumed premiums are required under proposed new §7.88(m)(1) to file the management's report of internal control over financial reporting; (ii) foreign or alien insurers that are subject to substantially similar requirements in their state of domicile are exempt from the internal control requirements in §7.88(m) pursuant to proposed new §7.88(e)(2); and (iii) in lieu of preparing and filing the management report of internal controls over financial reporting, certain insurers and HMOs (or group of insurers or HMOs) have the option under proposed new §7.88(m)(3) and (4) to file copies of the Section 404 report of the insurer or HMO or of the insurer's or HMO's parent company's Section 404 report.

Under proposed new §7.88(m)(2), the management of an insurer or HMO that has been required by the Commissioner to file the management's report of internal control over financial reporting must prepare the report and submit it to the Commissioner as directed by the Commissioner. Proposed new §7.88(m)(2) provides that the Commissioner may require an insurer or HMO regardless of the amount of the annual direct written and assumed premiums to file the management's report of internal control over financial reporting if the insurer or HMO is in any risk-based capital level event or meets one or more of the statutory hazardous financial condition standards. Therefore, the Department anticipates that the potential costs associated with proposed new §7.88(m)(2) will impact a relatively small number of insurers and HMOs. Those insurers or HMOs must meet all of the following criteria: (i) the insurer or HMO triggers a risk-based capital level event or meets one or more of the hazardous financial condition standards as provided in the Insurance Code Chapters 404, 441, 822, 841, 843, or 884, or rules adopted thereunder, including §§7.402, 8.1 - 8.4, and 11.810; (ii) the insurer or HMO is subject to an order, directive, or other requirement of the Commissioner to prepare and file a report on the insurer's or HMO's internal control over financial reporting issued pursuant to the Commissioner's authority under the Insurance Code §§404.003, 404.005, 404.053, 441.001(e), 441.005, 441.051 - 441.053, 441.102, 822.210, 822.211, 841.205 - 841.207, 843.151, 843.155, 843.157, 843.404, 843.406, and 884.206, or rules adopted thereunder, including §§7.402, 8.1 - 8.4, and 11.810; and (iii) the insurer or HMO is not compliant with the SOX, is not directly subject to

Section 404 of SOX, or is otherwise ineligible to take advantage of any of the cost savings options in proposed new §7.88(m)(3) and (4). The Section 404 report is required by Section 404 of the SOX.

In lieu of preparing and filing the management report of internal controls over financial reporting required by proposed new §7.88(m)(1) or (2), certain insurers and HMOs (or group of insurers or HMOs) have the option under proposed new §7.88(m)(3) and (4) to file copies of the Section 404 report of the insurer or HMO or of the insurer's or HMO's parent company's Section 404 report. Under proposed new §7.88(m)(3), an insurer or HMO or a group of insurers or HMOs may file the insurer's or HMO's or the insurer's or HMO's parent's Section 404 report and an addendum if the insurer or HMO or group of insurers or HMOs is (i) directly subject to Section 404; (ii) part of a holding company system whose parent is directly subject to Section 404; (iii) not directly subject to Section 404 but is a SOX-compliant entity; or (iv) a member of a holding company system whose parent is not directly subject to Section 404 but is a SOX-compliant entity. Proposed §7.88(m)(4) requires that the addendum that must accompany the Section 404 report authorized in proposed §7.88(m)(3) must be a positive statement by management that there are no material processes excluded from the Section 404 report with respect to the preparation of the insurer's or HMO's or group of insurers' or HMOs' audited statutory financial statements, including those items specified in the Insurance Code §401.009(a)(3)(B) – (H) and (b). Additionally, if there are any internal controls of the insurer or HMO or group of insurers or HMOs that have a material impact on

the preparation of the insurer's or HMO's or group of insurers' or HMOs' audited statutory financial statements and those internal controls are not included in the Section 404 report, the public insurer or HMO or group of insurers or HMOs may either file: (i) a report of internal control over financial reporting under proposed new §7.88(m)(1) or (2); or (ii) the Section 404 report and a report of internal control over financial reporting under proposed new §7.88(m)(1) or (2) for those internal controls not covered by the Section 404 report.

Under proposed new §7.88(m)(5), the insurer's or HMO's management report of internal control over financial reporting required in §7.88(m)(1) and (2) must include: (i) a statement that management is responsible for establishing and maintaining adequate internal control over financial reporting; (ii) a statement that management has established internal control over financial reporting and an opinion concerning whether, to the best of management's knowledge and belief, after diligent inquiry, its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles; (iii) a statement that briefly describes the approach or processes by which management evaluates the effectiveness of its internal control over financial reporting; (iv) a statement that briefly describes the scope of work that is included and whether any internal controls were excluded; (v) disclosure of any un-remediated material weaknesses in the internal control over financial reporting identified by management as of the immediately preceding December 31; (vi) a statement regarding the inherent limitations of internal control systems;

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

Proposed new §7.88(m)(6) provides that, for purposes of the required §7.88(m)(5)(E) disclosure of any un-remediated material weaknesses in the internal control over financial reporting identified by management, an insurer's or HMO's management may not conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there is one or more un-remediated material weaknesses in its internal control over financial reporting. Generally, an insurer or HMO will be required to perform a comprehensive review and analysis of their internal control and perform the §7.88(m)(5) and (6) functions over their entire control structure as a prerequisite to preparing the report required by proposed new §7.88(m)(1) or (2).

Proposed new §7.88(m)(7) requires the management of an insurer or HMO to document and make available upon financial condition examination, the basis of the opinions required by proposed new §7.88(m)(5). The opinions are requirements of proposed new §7.88(m)(5), such as proposed new §7.88(m)(5)(B), which requires an opinion, to the best of management's knowledge and belief after diligent inquiry, whether its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles. The opinions required by proposed new §7.88(m)(5), in turn, are a result of the requirements of proposed new §7.88(m)(1), (2), or (4), which, as

previously discussed, require the preparation by management of a report of an insurer's or HMO's or group of insurers' or HMOs' internal control over financial reporting. Under proposed new §7.88(m)(7), an insurer's or HMO's management must prepare a written memorialization of the basis or thought process used in deriving the opinions required by proposed new §7.88(m)(5). Proposed new §7.88(m)(7) does not expressly require that an insurer's or HMO's management follow a specific or prescribed protocol in documenting the basis for the opinions.

Proposed new §7.88(m)(8) expressly acknowledges and authorizes an insurer's or HMO's management to utilize its discretion as to the nature of the internal control framework used and the nature and extent of the §7.88(m)(7) documentation to enable the insurer or HMO management to form its opinions in a cost-effective manner. Therefore, proposed new §7.88(m)(7) and (8) together allow an insurer or HMO to exercise discretion and flexibility in determining its means of compliance, including the most cost-effective means for that particular insurer or HMO.

The Department anticipates that the amount of staff time and related costs associated with the preparation of the report on internal control over financial reporting required in proposed §7.88(m)(1) or (2) will vary considerably based upon a wide-range of factors, including: (i) the size and complexity of the insurer or HMO and its operations; (ii) the adequacy and level of complexity of the insurer's or HMO's systems of internal controls over financial reporting; (iii) the relative strength or weakness of the insurer's or HMO's electronic systems, including accounting systems, premiums systems, policy administration systems,

underwriting systems, claims systems, reinsurance systems and investment systems; (iv) whether a robust enterprise risk management systems exists; (v) the adequacy, size, and competency of the insurer's or HMO's accounting staff; (vi) the general corporate culture, concerning, for example, risk tolerance and adherence to accepted industry best practices; (vii) whether a relatively minor deficiency, a significant deficiency, or a material weakness is identified; and (viii) whether remediation efforts are necessary to address material weaknesses in the internal control structure. While the probable total costs of the functions related to the production and submission of the report required by proposed new §7.88(m)(1) or (2) and (3), (4), and (5) - (8) will vary for the preceding reasons, the Department anticipates that the actual total costs will primarily relate to the number, type, and wages of staff and the number of hours required for each staff member necessary to perform the functions required to comply with the proposed requirements for the management's report of internal control over financial reporting in §7.88(m)(1) or (2) and (3), (4), (5), (6), and (8). Because the amount of staff time and concomitant wage costs necessary to prepare the report will vary considerably, the total cost of compliance similarly will vary considerably from insurer or HMO to insurer or HMO. Nevertheless, the Department anticipates that most insurers or HMOs required to prepare a report of internal control over financial reporting under proposed new §7.88(m)(1) or (2) and (3), (4), (5), (6), and (8) will assemble a team of staff accounting and management professionals who have knowledge of the insurer or HMO, as well as of its books, records, accounting systems, and internal control structure. The Department

anticipates the size of the team will vary considerably in size from insurer or HMO to insurer or HMO because of the wide range of factors noted previously, but generally expects the staff team to range in size from 3 to 10 members. The Department anticipates that these insurers or HMOs will typically utilize a team that includes one or more staff accountants or auditors, who are compensated at an estimated mean hourly salary rate of $30.73 for accountants and auditors as set forth in the latest DOL Wage Estimates report. Regardless of the size of the team, the Department also anticipates that the team will typically be led by a senior-level executive who is familiar with the insurer's or HMO's accounting infrastructure such as the insurer or HMO's comptroller or chief financial officer. The Department anticipates that the senior-level executive leading the team, such as the insurer's or HMO's comptroller or chief financial officer, will be compensated at an estimated mean hourly salary rate of up to $79.81 for chief executives, as set forth in the latest DOL Wage Estimates report (May 2008). The Department further anticipates that the team will likely be supported by a staff member from the insurer's or HMO's information technology systems, such as a systems analyst. The Department anticipates that a systems analyst included on the staff team will be compensated at an estimated mean hourly salary rate of $36.41 for systems analysts, as set forth in the latest DOL Wage Estimates report. The Department anticipates that compensation amounts and practices will vary substantially between different insurers or HMOs because of the wide range of factors previously noted. Accordingly, these estimated compensation rates may differ from the actual compensation practices of any

one particular insurer or HMO. However, based on the Department's cost factors and analysis, each insurer and HMO has the information necessary to determine its compensation costs to prepare the annual management report of the insurer's or HMO's or group of insurers' or HMOs' internal control over financial reporting as required by proposed §7.88(m)(1) or (2) and (3), (4), (5), (6), and (8). The Department anticipates that some insurers or HMOs may elect at their option to utilize external accounting firms to assist in preparing the management reports required by proposed new §7.88(m)(1) or (2) and (3), (4), (5), (6), and (8). Unlike SOX Section 404, however, proposed new §7.88(m)(1) or (2) and (3), (4), (5), (6), and (8) do not require that an insurer's or HMO's external accountant assist in preparing the management report or provide an attestation report on the effectiveness of the internal controls over financial reporting. Thus, proposed new §7.88(m)(1) or (2) and (3), (4), (5), (6), and (8) do not require the use of an external accounting firm in preparing the management report. Therefore, the associated costs for an external auditing firm are not required to be incurred. The Department further anticipates that most insurers or HMOs will utilize the most cost effective means to comply with proposed new §7.88(m), including utilization of the potential cost savings provisions in proposed new §7.88(m)(8). As previously indicated, under proposed new §7.88(m)(8), an insurer's or HMO's management has discretion regarding the nature of the internal control framework used and the nature and extent of the §7.88(m)(7) documentation, including an assembly of or reference to existing documentation. This flexibility

will enable management to form its §7.88(m)(5) opinions in the most cost-effective manner.

The costs required to comply with proposed §7.88(m)(3) and (4) will be incurred by certain insurers or HMOs subject to proposed §7.88(m)(1) or (2). Proposed new §7.88(m)(3) and (4) provides potential cost savings measures for SOX-compliant entities, whether the entities are voluntarily SOX compliant or required to be SOX compliant. In order to avoid costs related to producing new reports required to comply with proposed §7.88(m)(1) or (2) that contain essentially similar and/or duplicative information, proposed new §7.88(m)(3) and (4) allow certain public insurers or HMOs to comply by filing copies of the insurer's or HMO's Section 404 report or the Section 404 report of the parent of the insurer or HMO and an addendum described by proposed new §7.88(m)(4). The Department anticipates that the majority of the public insurers or HMOs subject to proposed new §7.88(m)(1) and some of the insurers or HMOs subject to proposed new §7.88(m)(2) will be eligible to take advantage of the cost savings provisions contained in proposed new §7.88(m)(3) and (4). Moreover, the Department anticipates that a public insurer or HMO that meets the eligibility for the option under proposed new §7.88(m)(3) and (4) may elect that option in order to avoid the higher costs of compliance to prepare and to file a management report of internal controls over financial reporting under proposed new §7.88(m)(1) or (2).

The Department anticipates that the majority of insurers or HMOs, or groups of insurers or HMOs, that are eligible for and elect the option under

proposed new §7.88(m)(3) and (4), will incur negligible costs from filing the addendum required by proposed new §7.88(m)(4). The Department anticipates that the majority of insurers or HMOs, or groups of insurers or HMOs, with annual direct written and assumed premiums of $500 million or more are publicly traded and therefore are required to comply with SOX or have voluntarily taken action to comply with SOX, including addressing any un-remediated internal control deficiencies. Accordingly, the Department anticipates that the majority of insurers or HMOs subject to proposed new §7.88(m)(1) and at least some of the insurers or HMOs subject to proposed new §7.88(m)(2) will be able to file their Section 404 reports with a positive statement by management, as authorized under proposed new §7.88(m)(3) and (4). In these cases, the cost of compliance will result from the preparation and submission of the addendum with the positive statement. The Department anticipates that an insurer or HMO will delegate the responsibility for preparing the addendum to an individual on the insurer's or HMO's staff who is familiar with accounting requirements and the books, records, and systems of the insurer or HMO. The Department anticipates that the cost of compliance for the completion and submission of the addendum will range from a negligible amount up to approximately $150. This estimate is based on a member of the insurer's or HMO's management staff reviewing and approving the prepared information within a one to three-hour period. The salary for this staffer is estimated at the mean salary rate of $53.95 per hour, as set forth for similar management positions in the latest DOL Wage Estimates report.

The Department also anticipates that some insurers or HMOs subject to proposed new §7.88(m)(1) or (2) and (3) and (4) will incur costs for the preparation of an annual management report of the insurer's or HMO's or group of insurers' or HMOs' internal control over financial reporting and the submission of that report to the Commissioner, as required in proposed new §7.88(m)(1) or (2) and (5), (6), and (8), if they have internal controls that are not included in the Section 404 report, and those internal controls have a material impact on the preparation of the audited financial statements. Also, the probable total costs will vary significantly based on the number and nature of internal controls not included in the Section 404 report that have a material impact on the preparation of the audited financial reports. Thus, for example, the size of the staff and management team required to be assembled will vary considerably based on whether (i) a newly created comprehensive report is required because the insurer or HMO's Section 404 report excludes many internal controls which are material to the preparation of the audited financial statements, or (ii) whether only a limited report is needed because the insurer or HMO already has a Section 404 report, but that report excludes only one or two internal controls that are material to the preparation of the entity's financial statement.

The costs required to comply with proposed §7.88(m)(5) - (8) will be incurred by those insurers or HMOs subject to proposed §7.88(m)(1) or (2). The Department anticipates that the relatively small number of large, non-public insurers or HMOs under proposed §7.88(m)(1) and the relatively small number of insurers or HMOs under proposed §7.88(m)(2) will incur significant costs under

proposed new §7.88(m)(5), (6), and (8). The Department anticipates that the primary costs of compliance associated with proposed new §7.88(m)(5), (6), and (8) will relate to the insurer or HMO's staff time that is necessary to conduct the planning, analysis, document preparation, remediation efforts, and subsequent monitoring efforts pertaining to the report of internal control over financial reporting.

The Department anticipates that the §7.88(m)(5) and (6) functions may require a comprehensive project for certain insurers or HMOs that spans several months from inception of the project to report generation. An insurer's or HMO's team of staff professionals and management will be required to perform a number of specific functions, including (i) planning for the overall project and related administration, including a structured and measurable approach to testing and evaluating internal controls; (ii) performing the actual tests of the design and effectiveness of material controls over significant accounting functions; (iii) evaluating the test results in order to determine if the internal control is effective; (iv) determining if remediation is necessary if a test result reveals a significant deficiency in an internal control; (v) assessing the sufficiency of documentation of internal control; (iv) in instances where adequate documentation may be lacking or insufficient, creating new documentation of internal control; and (v) preparing management's report on internal control that includes the statements required by proposed new §7.88(m)(5). An insurer or HMO may elect at its option to utilize external accountants and consultants to assist in the preparation of the required management report. If this option is elected, additional

compliance costs will be incurred. However, because there is no requirement that external accountants and consultants be used in the preparation of the reports required under proposed new §7.88(m)(3), (4), (5), (6), and (8), the insurer and HMO have complete control over whether to utilize this option and thus incur these costs. For example, the internal control report requirements in proposed new §7.88(m)(5) require an attestation from management and do not require an attestation from an external accountant. Accordingly, the Department anticipates that most insurers or HMOs typically will utilize their own staff to prepare the required management report on internal controls. Additionally, although the project may require a substantial amount of time for completion, the Department anticipates that the insurer's or HMO's staff will typically be able to concurrently engage in their routine functions and prepare the required report. The Department anticipates that prudently operated insurers or HMOs often will incur comparatively less costs to comply with proposed new §7.88(m)(1) or (2), and (3), (4), (5), (6), and (8) compared to less prudently operated insurers or HMOs for the following reasons. First, the importance of maintaining adequate internal controls in order to ensure the integrity and accuracy of financial statements is broadly accepted throughout a wide range of industries, including the insurance industry, and this importance is specifically embraced by the accounting profession. Second, independent accountants are already required by the Insurance Code §401.019 to consider internal control matters while conducting audits of insurers or HMOs. Additionally, the Insurance Code §401.013(a)(3)(B) requires independent accountants to specifically state to the

Department that the independent accountants will conform to their professional standards of conduct. Third, the professional standards of conduct for independent accountants require that they review the adequacy of internal controls during the course of audits of financial statements of insurers or HMOs. Accordingly, the Department anticipates that prudently operated insurers or HMOs typically will already have an adequate system of internal controls and, compared to less prudently operated insurers or HMOs, will incur relatively less costs for compliance with the proposed new §7.88(m)(1) or (2) and (3) – (8) internal control requirements. Conversely, insurers or HMOs that may be less prudent in their business operations are likely to have inadequate systems of internal control and may incur relatively greater costs of compliance as a result of the proposed new §7.88(m)(1) or (2) and (3) – (8) internal control requirements to identify and address un-remediated material weaknesses in their internal control structure. Any costs incurred to address material weaknesses in internal control under proposed new §7.88(m)(6) – (8) will reduce the risk that insurers or HMOs may operate in a potentially hazardous financial condition. Therefore, it is the Department's position that these additional costs for less prudently operated insurers or HMOs are justified because the existence of un-remediated material weaknesses in internal control may increase the risk that an insurer or HMO is operating in a potentially hazardous financial condition.

As previously discussed in detail, the Department anticipates that most insurers or HMOs subject to proposed new §7.88(m)(1) or (2) will assemble a team of accountants, management staff, and other professionals to produce the

required report on internal control. The Department further anticipates that the same team of staff, or a subset of that team, will prepare the §7.88(m)(7) documentation for the basis of the opinions required by proposed new §7.88(m)(5). Accordingly, the Department anticipates that the costs of compliance with proposed §7.88(m)(7) will primarily relate to the wages attributable to these employees and the amount of time that is required to produce this documentation. These wage expenses on an hourly basis and other cost factors have been previously detailed in the description of the costs to comply with proposed new §7.88(m)(1) or (2) and (5), (6), and (8) and are equally applicable as estimated costs for compliance with proposed new §7.88(m)(7). The amount of time that is required to prepare the documentation required by proposed new §7.88(m)(7) will vary based on the same factors that have been previously detailed for compliance with proposed new §7.88(m)(1) or (2) and (5), (6), and (8). These factors include (i) whether an insurer or HMO already has internal controls in place, in which case relatively less testing for reliability may be needed, or (ii) whether a new internal control(s) is required, in which case relatively more testing for reliability may be warranted. The Department, however, anticipates that the amount of time, and thus probable total compliance costs to produce the required §7.88(m)(7) documentation, will be substantially less than that for proposed new §7.88(m)(1) or (2) and (5), (6), and (8). The Department anticipates that compliance with proposed §7.88(m)(7) will typically require estimated staff time ranging from 40 – 80 hours with estimated total costs ranging from $1,376 to $2,753.

As previously indicated, proposed new §7.88(m)(8) provides that an insurer's or HMO's management has discretion regarding the nature of the internal control framework used and the nature and extent of the §7.88(m)(7) documentation, in order to form its opinions in a cost-effective manner and may include an assembly of or reference to existing documentation. The Department does not anticipate that an insurer or HMO will incur any additional costs of compliance as a result of proposed new §7.88(m)(8). Rather, the purpose of proposed new §7.88(m)(8) is to allow the exercise of discretion so that an insurer or HMO can lower its cost of compliance with proposed new §7.88(m)(5) and (7). The Department further anticipates that insurers or HMOs will typically elect to exercise the discretion provided under proposed new §7.88(m)(8) in order to lower the costs of compliance with proposed new §7.88(m)(5) and (7).

In addition to the several mitigating cost factors related to compliance with the proposed §7.88(m) requirements that have already been discussed, there are three additional proposed provisions that will substantially reduce the compliance costs. First, the Department anticipates that the majority of insurers or HMOs subject to proposed new §7.88(m)(1) and some of the insurers or HMOs subject to proposed new §7.88(m)(2) will elect to file copies of their Section 404 reports and addendums with the Commissioner and will not incur additional substantial costs for preparing and filing the report of internal control over financial reporting as a result of proposed new §7.88(m). Second, the Department anticipates that the majority of public insurers or HMOs subject to §7.88(m)(1) and the insurers or HMOs subject to §7.88(m)(2) will elect to submit copies of existing reports

electronically to the Commissioner, thereby incurring nominal costs. Electronic submission will reduce administrative costs because hard copy documents will not have to be prepared and submitted to one or more regulatory jurisdictions. Third, as previously discussed in the Introduction of this proposal, several recent polls reflect that insurance regulators in virtually all other states have either adopted or plan to adopt substantially similar requirements to the NAIC's revised Model Audit Rule prior to or during calendar year 2010. Thus, Texas domestic insurers or HMOs authorized to conduct business in Texas as well as in other states are expected to comply with substantially similar internal control requirements in other states, effective beginning in calendar year 2010, even if this proposed section is not adopted. Also, Texas domestic insurers or HMOs authorized to conduct business in Texas as well as in other states will have reduced filing requirements in other states if the proposal is adopted. Because the proposal is based on an NAIC model regulation, the Department anticipates that the requirements in other states will also include provisions that are similar to proposed new §7.88(e)(2). Under proposed new §7.88(e)(2), a foreign or alien insurer or HMO required to file management's report of internal control over financial reporting in another state is exempt from filing the report in this state if the other state has substantially similar reporting requirements and the report is filed with the commissioner in that state in the time specified. Therefore, if the Department does not adopt this proposal, foreign and alien insurers or HMOs authorized to operate in Texas and in another state or states will still be required to incur the costs necessary to prepare and file the management's report of

internal controls in the other state or states. Conversely, unless the Department adopts the proposal, Texas domestic insurers or HMOs that operate in other states will be required to file management's report of internal control over financial reporting in those other states that adopt the NAIC's revised Model Audit Rule. Therefore, as a result of the adoption of this proposal, Texas domestic insurers or HMOs authorized to operate in Texas and in other states will not be required to incur costs to file such reports in other states because of the other state's exemptions like the one in proposed new §7.88(e).

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. The Government Code §2006.002(c) requires that if a proposed rule may have an economic impact on small businesses or micro businesses, state agencies must prepare as part of the rulemaking process an economic impact statement that assesses the potential impact of the proposed rule on these businesses and a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the rule. The Government Code §2006.001(2) defines "small business" as a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit, is independently owned and operated, and has fewer than 100 employees or less than $6 million in annual gross receipts. The Government Code §2006.001(1) defines "micro business" similarly to "small business" but specifies that such a business may not have more than 20 employees. The Government Code §2006.001(1) does not specify a

maximum level of gross receipts for a “micro business.” The Government Code §2006.002(f) requires a state agency to adopt provisions concerning micro businesses that are uniform with those provisions outlined in the Government Code §2006.002(b) - (d) for small businesses.

Proposed Provisions with No Adverse Economic Impact. In accordance with the Government Code §2006.002(c), the Department has determined that the following proposed provisions, which have compliance costs that are discussed in detail in the Public Benefit/Cost Note, will not have an adverse economic effect on small or micro business insurers or HMOs: (i) §7.88(e)(1) and (2) requirements relating to foreign or alien insurers or HMOs; (ii) §7.88(d)(1) - (4) requirements relating to filing the audited financial report; (iii) §7.88(h)(1) exemption to the proposed new §7.88(h)(1) limitation on a lead partner or other person rendering an audited financial report under certain specified circumstances; (iv) §7.88(h)(2) filing requirements relating to the proposed §7.88(h)(1) exemption to the proposed new §7.88(h)(1) limitation on a lead partner or other person rendering an audited financial report under certain specified circumstances; (v) §7.88(h)(3) prohibitions relating to certain specified functions that may not be performed by the independent accountant that prepares the insurer or HMO's audited financial report; (vi) §7.88(h)(6) exemption to the proposed new §7.88(h)(4) prohibitions relating to certain specified services that an accountant cannot provide to the insurer or HMO at the time of the audit; (vii) §7.88(h)(10) exemption to the proposed new §7.88(h)(10) requirements relating to certain individuals who may not be recognized by the

Commissioner as a qualified or independent accountant; (viii) §7.88(h)(11) prohibitions relating to individuals or firms that have engaged in certain specified acts who as a result of those acts cannot prepare an audited financial report; (ix) §7.88(h)(12) filing requirements for exemption approvals granted under proposed new §7.88(h)(4) or (10); (x) §7.88(j) requirements relating to preparing and filing the communication of internal control matters noted in the audit; (xi) §7.88(k)(2) requirements relating to the independence of the audit committee membership; (xii) §7.88(k)(4) requirements related to a hardship waiver from the audit committee requirements in proposed new §7.88(k)(1), (2)(B), and (5) – (12); (xiii) §7.88(k)(7) requirements relating to the audit committee membership; (xiv) §7.88(k)(9) requirements relating to the cessation of an audit committee member's independence for reasons outside the member's control; (xv) §7.88(k)(10) requirements relating to the controlling person's option to elect the audit committee of an entity that controls an insurer or HMO; (xvi) §7.88(k)(11) and (12) requirements relating to the independent accountant's reporting requirements to the audit committee; (xvii) §7.88(m)(1) and (n)(2) requirements relating to the requirement that certain insurers or HMOs with $500 million or more in annual direct and assumed premiums prepare an annual management report of the insurers or HMOs' internal control over financial reporting and submit that report annually to the Commissioner; and (xviii) §7.88(m)(3) and (4) relating to the optional requirements to file copies of the Section 404 report of the insurer or HMO or of the insurer's or HMO's parent company's Section 404 report

in lieu of preparing and filing the management report of internal controls over financial reporting required under §7.88(m)(1).

The proposed new §7.88(e)(1)(A) - -(C) requirements for foreign or alien insurers or HMOs exempt under the Insurance Code §401.007(a) to submit to the Commissioner copies of certain filings made in other states are consistent with the current filing requirements prescribed in the Insurance Code §§401.004, 401.007(a) – (c), 401.013(a), 401.017, and 401.019. Therefore, insurers or HMOs, including small and micro business insurers or HMOs, are already required to comply with proposed §7.88(e)(1), and there are no additional compliance costs as a result of these proposed requirements.

Proposed new §7.88(d)(1) - (4), in conjunction with proposed new §7.88(b)(1), relate to requirements for filing an annual audited financial report on or before June 1 or June 30, or another due date established by the Commissioner for the preceding calendar year, beginning with calendar year 2010. As explained in detail in the Public Benefit/Cost Note part of this proposal, the Department anticipates that many insurers or HMOs, including small and micro business insurers or HMOs, will be required comply with the proposed new §7.88(d)(1) requirement to file their audited financial reports on or before June 1 for the preceding calendar year, beginning with calendar year 2010. The June 1 filing date is consistent with the filing requirements of most, if not all, other states, and as a result, the Department does not anticipate there will be any additional cost of compliance for small and micro business insurers or HMOs that are authorized to conduct the business of insurance in other states. Additionally,

small or micro business insurers or HMOs will not be subject to the June 1 filing requirement in proposed new §7.88(d)(1) that is mandated for insurers or HMOs authorized in and doing business in Texas only but that are affiliated with insurers or HMOs that do business in other states and are required by those other states to file their audited financial reports on or before June 1. In order for a insurer or HMO to meet the "independently owned and operated" requirement for a small business under the Government Code §2006.001(2), it cannot be a member of a group comprised of one or more insurers or HMOs authorized and actually doing the business of insurance in another state. Also, some insurers or HMOs, including small or micro business insurers or HMOs, may qualify for the §7.88(d)(2) limited exception to proposed new §7.88(d)(1), and thus, be authorized to file their audited financial reports on or before June 30 for the preceding year. The Department does not anticipate there will be any additional cost of compliance for small or micro business insurers or HMOs that meet the limited exception because the June 30 filing date in proposed new §7.88(d)(2) is the same as the filing date under current Texas statutory requirements.

Proposed new §7.88(h)(1), (2), (3), (6), (10), (11), and (12) relate to the new accountant independence and qualification requirements. A small or micro business insurer or HMO applying for the §7.88(h)(1) exemption to the proposed new §7.88(h)(1) limitation on a lead partner or other person rendering an audited financial report under certain specified circumstances would incur nominal costs for filing for the exemption, which the Department does not anticipate would have an adverse economic impact on such insurers or HMOs.

Under proposed new §7.88(h)(2), a small or micro insurer or HMO must file, along with its annual statement filing, the exemption approval granted under proposed new §7.88(h)(1) with the states in which it is doing business or is authorized to do business and with the NAIC; if a state other than Texas accepts electronic filing with the NAIC, the insurer or HMO must file the approval in an electronic format acceptable to the NAIC. The Department has determined that a small or micro business insurer or HMO would incur nominal costs for such filings, and such costs would not have an adverse economic impact on such small or micro business insurers or HMOs.

Proposed new §7.88(h)(3)(A) prohibits a insurer or HMO's independent accountant from (i) functioning in the role of management, (ii) auditing the independent accountant's own work, or (iii) serving in an advocacy role for the insurer or HMO. For the reasons detailed in the Public Benefit/Cost Note part of this proposal, the proposed new §7.88(h)(3)(A) requirements are not expected to result in any new or additional compliance costs for any insurer or HMO, including a small or micro business insurer or HMO.

Proposed new §7.88(h)(3)(B), which restates the existing independent accountant independence and qualification requirements in the Insurance Code §401.011(d)(4), does not impose any additional requirements on any small or micro business insurer or HMO that are not currently mandated by statute. Any costs to comply with these restated requirements are the result of the enactment of the Insurance Code §401.011(d), and are not a result of the adoption, enforcement, or administration of proposed §7.88(h)(3)(B). Therefore, proposed

new §7.88(h)(3)(B) will not have an adverse economic impact on small and micro business insurers or HMOs.

Proposed new §7.88(h)(6) allows certain insurers or HMOs with direct written and assumed premiums of less than $100 million in any calendar year to apply for an exemption to the proposed new §7.88(h)(4) prohibitions relating to the types of services or functions that the independent accountant is not allowed to provide to the insurer or HMO. Such insurers or HMOs may request an exemption from the requirements of proposed new §7.88(h)(4) by filing with the Commissioner a written statement explaining why the insurer or HMO should be exempt. The Department estimates that any small or micro business insurer or HMO that applies for such an exemption would incur costs associated with the preparation and mailing of the exemption application. The Department anticipates that these costs will be minimal, typically ranging from approximately $50 to $150. The Department has determined that these nominal costs would not have an adverse economic impact on small and micro business insurers or HMOs.

Proposed new §7.88(h)(10) prohibits the Commissioner from recognizing as qualified or independent, an accountant for a particular insurer or HMO if a member of the board, the president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for the insurer or HMO, was employed by the accountant and participated in the audit of that insurer or HMO during the one-year period preceding the date on which the most current statutory opinion is due. Also,

under proposed new §7.88(h)(10), an insurer or HMO may apply for an exemption from the §7.88(h)(10) requirements on the basis of unusual circumstances. Such insurers or HMOs may request an exemption from the proposed new §7.88(h)(10) prohibition by filing with the Commissioner a written statement explaining any unusual circumstances of why the insurer or HMO should be exempt from the §7.88(h)(10) prohibition. Any small or micro business insurer or HMO that applies for such an exemption would incur costs associated with the preparation and mailing of the exemption application. The Department anticipates that these costs will be minimal, typically ranging from approximately $50 to $150. The Department has determined that these nominal costs would not have an adverse economic impact on small and micro business insurers or HMOs.

Proposed §7.88(h)(11) restates the existing independent accountant independence and qualification requirements in the Insurance Code §401.011(d)(1) - (3). It prohibits the Commissioner from recognizing as a qualified independent accountant or accepting an audited financial report prepared wholly or partly by an individual or firm that the Commissioner finds meets certain specified criteria. Any costs to comply with these restated requirements are the result of the enactment of the Insurance Code §401.011(d), and are not a result of the adoption, enforcement, or administration of this proposal. Therefore, proposed §7.88(h)(11) will not have an adverse economic impact on small and micro business insurers or HMOs.

If the Commissioner approves an exemption under proposed new §7.88(h)(6) or (10) for a small or micro business insurer or HMO, the insurer or HMO would be required to comply with the filing requirements in proposed new §7.88(h)(12). Under proposed new §7.88(h)(12), an insurer or HMO, including a small or micro business insurer or HMO, must file, along with its annual statement filing, the Commissioner's exemption approval with the states in which it is doing business or is authorized to do business and with the NAIC; if a state other than Texas accepts electronic filing with the NAIC, the insurer or HMO must file the approval in an electronic format acceptable to the NAIC. The Department anticipates that the total probable cost of preparing the information required under proposed new §7.88(h)(12) will vary but will typically be less than $100. The Department further anticipates that a member of the insurer or HMO's management staff could review and approve the prepared information in less than 30 minutes, at an estimated mean salary rate of $53.95 per hour, as set forth for similar management positions in the May 2008 DOL Texas Wage Estimates. Additionally, the cost for actually submitting the prepared information to the states in which the insurer or HMO is doing or is authorized to do business and with the NAIC will be minimal because most such filings will be done electronically. The Department has determined that these nominal costs would not have an adverse economic impact on small and micro business insurers or HMOs.

Proposed new §7.88(j) specifies the requirements applicable to non-exempt insurers or HMOs, including small and micro business non-exempt

insurers or HMOs, for preparing and filing the communication of internal control matters noted in the audit. As previously explained, the reporting required under proposed new §7.88(j) is consistent with the new Statement on Auditing Standard No. 112 and the Insurance Code §401.013(a)(3)(B) and §401.019. Also, an independent accountant is expected to conform to SAS No. 112, as contemplated under the Insurance Code §401.013(a)(3)(B). As a result, proposed new §7.88(j) does not impose any new or additional requirements to those provided under the Insurance Code §401.013(a)(3)(B) and §401.019, and therefore, is not expected to result in any compliance costs that are in addition to those costs incurred by a small or micro insurer or HMO required to meet the current reporting requirements in §401.013(a)(3)(B) and §401.019 of the Insurance Code. Therefore, the Department has determined that proposed new §7.88(j) will not have an adverse economic impact on any small or micro business insurer or HMO.

Proposed new §7.88(k)(2)(A) and (B) require a non-exempt insurer or HMO with $300 million or more in direct written and assumed premiums for the preceding calendar year to establish an audit committee with a certain percentage of independent members. Based on an analysis of the financial data collected by the Department, including the annual gross premium and corporate structure of licensed insurers or HMOs, the Department anticipates that proposed new §7.88(k)(2)(A) and (B) will not apply to any insurers or HMOs that qualify as small or micro businesses under the Government Code §2006.001. Proposed new §7.88(k)(2)(C) provides that except as provided in §7.88(k)(3), a non-exempt

insurer or HMO with less than $300 million in direct and assumed premiums for the preceding calendar year is not required to comply with the §7.88(k)(2) independence requirements for its audit committees. The Department has determined, therefore, that there is no adverse economic impact on small or micro insurers or HMOs as a result of proposed §7.88(k)(2)(C).

Under proposed new §7.88(k)(4), an insurer or HMO with premium of less than $500 million in direct written and assumed premiums (subject to certain exclusions in determining the amount of direct written and assumed premiums specified in §7.88(k)(4) and (5)) may apply to the Commissioner for a hardship waiver from the audit committee requirements in proposed new §7.88(k)(1), (2), and (5) – (12). If the Commissioner approves the waiver, the insurer or HMO is required to file, with its annual statement filing, the approval with the states in which it does business or is authorized to do business and with the NAIC. Those small or micro business insurers or HMOs that elect to apply for a waiver under proposed new §7.88(k)(4) will incur certain optional administrative costs in the preparation and submission of the waiver request. The Department has determined that these elective costs will be nominal, typically less than $50 - $100. The Department has determined that these nominal costs would not have an adverse economic impact on small and micro business insurers or HMOs.

Proposed new §7.88(k)(7) requires each member of the audit committee to be a member of the board of directors of the insurer or HMO or, at the election of the controlling person, a member of the board of directors of an entity that controls the group of insurers or HMOs, as provided under §7.88(k)(10) and

described under §7.88(c)(3). The Department does not anticipate that additional costs will be incurred to initially set up the audit committee structure under proposed new 7.88(k)(7), and therefore, this requirement will not have an adverse impact on small or micro business insurers.

Proposed new §7.88(k)(9) allows an audit committee member that ceases to be independent for reasons outside the member's control to remain an audit committee member for a certain specified time if the responsible entity gives notice to the Commissioner. Under proposed new §7.88(k)(3), the Commissioner may require the insurer or HMO's board to enact improvements to the independence of the audit committee membership if the insurer or HMO meets one or more of three specified criteria relating to financially hazardous conditions. Proposed new §7.88(k)(9) is not applicable to any insurers or HMOs, including small or micro business insurers or HMOs, required to enact improvements to the independence of the audit committee membership under proposed new §7.88(k)(3).

Under proposed new §7.88(k)(10), the audit committee of an entity that controls an insurer or HMO may, at the election of the controlling person, be the insurer's or HMO's audit committee. In order for the controlling person to elect this option, proposed new §7.88(k)(10) requires the ultimate controlling person to provide a written notice of the affected insurers or HMOs with the Commissioner. The Department has determined that these elective costs will be nominal, typically less than $50 - $120. The Department has determined that these

nominal costs would not have an adverse economic impact on small and micro business insurers or HMOs.

Proposed new §7.88(k)(11) requires the audit committee to require an insurer's or HMO's independent accountant to report to the audit committee in accordance with the requirements of Statement on Auditing Standards (SAS) No. 114, "The Auditor's Communication With Those Charged With Governance," or a successor document. Under proposed new §7.88(k)(12), if an insurer or HMO is a member of an insurance holding company system, the report required by §7.88(k)(11) may be provided to the audit committee on an aggregate basis for insurers or HMOs in the holding company system if any substantial differences among insurers or HMOs in the system are identified to the audit committee. In accordance with the Insurance Code §§401.001(1), 401.011, and 401.013, independent accountants engaged by insurers or HMOs are already required to conform with SAS, including SAS No. 114. Therefore, proposed new §7.88(k)(11) or (12) does not impose any new or additional requirements on insurers or HMOs, including small or micro business insurers or HMOs. There is a second reason why the Department has determined that proposed new §7.88(k)(11) and (12) will not result in any new or additional costs for any insurers or HMOs, including small or micro business insurers or HMOs. All insurers or HMOs, including small or micro business insurers or HMOs, that are authorized to write in another state, will be subject to that state's model audit regulations, which, as previously explained, will include substantially similar requirements to those in proposed new §7.88(k)(11) or (12).

The requirements in proposed new §7.88(m)(1) and (n)(2) only apply to non-exempt insurers or HMOs with $500 million or more in annual direct and assumed premiums. Based on an analysis of the financial data collected by the Department, including the annual gross premium and corporate structure of licensed insurers or HMOs, the Department has determined that proposed new §7.88(m)(1) and (n)(2) will not apply to insurers or HMOs that qualify as small or micro businesses under the Government Code §2006.001.

Proposed new §7.88(m)(3)(A) – (D) specifies the criteria that must be met for an insurer or HMO or a group of insurers or HMOs to be allowed to file the insurer or HMO’s or the insurer or HMO’s parent's Section 404 report and an addendum to comply with the requirement to file a report of internal control over financial reporting. Proposed new §7.88(m)(4) specifies that the Section 404 report must include those internal controls of the insurer or HMO or group of insurers or HMOs that have a material impact on the preparation of the insurer or HMO’s or group of insurer or HMO’s audited statutory financial statements. Proposed new §7.88(m(4) specifies other requirements relating to the required addendum and what may be filed if there are internal controls of the insurer or HMO or group of insurers or HMOs that have a material impact on the preparation of the audited statutory financial statements and those internal controls are not included in the Section 404 report. The Department has determined that proposed new §7.88(m)(3) and (4) will not apply to insurers or HMOs that qualify as small or micro businesses under the Government Code §2006.001.

Potential Economic Impact of Audit Committee Requirements and Accountant Qualifications and Independence Requirements on Small and Micro Businesses. As required by the Government Code §2006.002(c), the Department has determined that approximately 25 – 50 insurers or HMOs that are subject to the proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), and (k)(6) audit committee requirements and the proposed new §7.88(h)(1), (3) – (4), and (10) accountant qualifications and independence requirements may qualify as small or micro businesses under the Government Code §2006.001. This estimated number of small or micro business insurers or HMOs is based on an analysis of the financial data collected by the Department, including the annual gross premium of licensed insurers or HMOs. The estimated 25 - 50 insurers or HMOs consist primarily of small or micro domestic insurers or HMOs that write between $1 million and $6 million in direct premium and that are required to file an audited financial report under the Insurance Code Chapter 401, Subchapter A. Small or micro business insurers or HMOs writing less than $1 million in direct premiums in Texas are not included in the estimated 25 - 50 small or micro business insurers or HMOs because the Department anticipates that these insurers or HMOs will continue to utilize the exemption for certain small insurers or HMOs specified in the Insurance Code §401.006. Section 401.006, which was initially enacted in 1989 as Article 1.15A(4) (and repealed and re-adopted as §401.006 without substantive change in the Insurance Code revision, Acts 2005, 79th Legislature, Chapter 727, §1, effective April 1, 2007) exempts an insurer or HMO that has less than $1 million in direct premiums written in Texas and less

than $1 million in nationwide assumed premiums under reinsurance agreements during a calendar year from the requirement to file an audited financial report under Chapter 401, Subchapter A. To qualify for the exemption, the insurer or HMO is required to submit an affidavit, made under oath by one of the insurer or HMO's officers, that specifies the amount of direct premiums written in Texas during the calendar year. Also, the estimated 25 - 50 small or micro business insurers or HMOs does not include certain foreign or alien small or micro business insurers or HMOs that are exempted from the proposed rule pursuant to the Insurance Code §401.007 and proposed new §7.88(e)(1), or certain small or micro business insurers or HMOs that are exempted from the proposed rule pursuant to the hardship exemption in the Insurance Code §401.008.

The Department, however, does not anticipate that all estimated 25 – 50 small or micro business insurers or HMOs will experience an adverse economic impact. These proposed new requirements reflect prudent business practices that the Department expects many insurers or HMOs, including small and micro business insurers or HMOs, already comply with on a voluntary basis. However, a small or micro business insurer or HMO that is not already voluntarily complying with the proposed new audit committee requirements or the proposed new accountant qualifications and independence requirements may experience an adverse economic impact. As a result, the Department anticipates that some of the 25 – 50 small or micro business insurers or HMOs subject to these proposed requirements will experience an adverse economic impact.

Proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), and (k)(6) audit

committee requirements for certain non-exempt small or micro business insurers or HMOs. The Department's cost analysis for compliance with the audit committee requirements in the Public Benefit/Cost Note portion of this proposal is equally applicable to those insurers or HMOs that qualify as small or micro businesses under the Government Code §2006.001(1) and (2). As discussed, a small or micro business insurer or HMO potentially would incur costs under proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), and (k)(6) to establish an audit committee to carry out certain functions and responsibilities pertaining to the appointment, compensation, and oversight of the work of the insurer or HMO's independent accountant, including the resolution of any disagreements between the independent accountant and the management of the insurer or HMO regarding financial reporting for the purpose of preparing or issuing the audited financial report or related work under the Insurance Code Chapter 401, Subchapter A. If the insurer or HMO does not designate an audit committee, then proposed new §7.88(b)(3) provides that the insurer or HMO's entire board of directors shall constitute the audit committee. The Department anticipates that the majority of small and micro business insurers or HMOs subject to the audit committee requirements typically either already utilize an audit committee, or carry out audit committee functions at the board of directors level, either voluntarily or in order to comply with state or federal laws. In either case, the Department does not anticipate that additional costs will be incurred to initially set up the audit committee structure. Also, the Department anticipates that, in order to comply with the Texas Insurance Code or the laws of other states, a large

percentage of small or micro business insurers or HMOs that are authorized in Texas currently have audit committees or boards of directors that carry out most, if not all, of the audit committee requirements specified in proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), and (k)(6). The Department, however, expects that certain small or micro business insurers or HMOs that are subject to the proposed audit committee requirements currently do not utilize audit committees or their board of directors in a manner and method substantially similar, in whole or in part, to the manner and method required under proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), and (k)(6). In these instances, the Department anticipates that some additional costs will be incurred by these small or micro business insurers or HMOs to comply with these audit committee requirements. The Department anticipates that the total probable compliance cost will vary substantially among insurers or HMOs, regardless of size, and will depend on factors unique to each insurer or HMO, such as the extent to which a insurer or HMO already has established and utilizes an audit committee or board or directors to carry out the audit committee functions contemplated in the proposal. Unless these functions already are being performed, a small or micro business insurer or HMO will need to develop and implement an audit committee approval process to review and approve independent accountant appointments and compensation packages, and to oversee the independent accountant's work, as provided under proposed new §7.88(c)(3) and (k)(6). A small or micro business insurer or HMO also may need to develop an audit committee approval process to review and approve audit and non-audit services that an independent

accountant is authorized to provide to the insurer or HMO in accordance with proposed new §7.88(h)(7) – (9). Additionally, to the extent a small or micro business insurer or HMO's audit committee or board of directors is not already performing the audit committee functions required under proposed new §7.88(c)(3), (h)(7) – (9), and (k)(6), the small or micro business insurer or HMO possibly may incur some additional audit related compliance costs. These possible additional costs relate to situations where an insurer or HMO may elect to provide additional compensation to its audit committee members to perform new functions relating to the required audits. The proposal does not expressly require that additional compensation costs be incurred under proposed new §7.88(c)(3), (h)(7) – (9), and (k)(6) by any insurers or HMOs, including small or micro business insurers or HMOs. Accordingly, the Department does not anticipate that all small or micro business insurers or HMOs will incur related costs of compliance. Nevertheless, the Department anticipates that some small or micro business insurers or HMOs may opt to consider providing this additional compensation to its audit committee members. These additional costs, if any, to increase compensation to its current audit committee or board members will vary substantially depending on such factors as (i) the type of the insurer or HMO; (ii) the location of its offices; (iii) the amount and complexity of its business; and (iv) the insurer or HMO's particular business practices related to the compensation of directors, including the various types of compensation paid to directors, such as annual board member compensation, fees for attending board meetings, fees for serving on committees, and stock options. The Department anticipates that the

compensation arrangements will vary substantially depending on such factors as (i) the complexity of the insurer or HMO's operations; (ii) the scope and complexity of the duties assumed by the board member or audit committee member; (iii) whether the insurer or HMO employs certain business models specifically designed to reduce administrative costs; and (iv) whether a controlling person elects to have the audit committee of an entity that controls an insurer or HMO also be the audit committee for the insurer or HMO. Therefore, the economic impact on an individual small or micro business insurer or HMO may vary widely among small or micro business insurers or HMOs. For example, the Department anticipates that some small or micro business insurers or HMOs may elect to compensate their board and audit committee members based on flat dollar amounts per year of service whereas others may elect to base this compensation on stock options or a combination of flat rates plus stock options. The Department anticipates that some small or micro business insurers or HMOs may elect to utilize even more different types of compensation arrangements, such as a payment for each board meeting attended and audit committee meeting attended. The actual cost to each small or micro business insurer or HMO to increase compensation to existing board or audit committee members will depend on factors unique to each insurer or HMO. Regardless of the insurer or HMO's compensation practice, these costs will be under the control of the small and micro business insurers or HMOs that elect to incur these additional compensation expenses. Each small or micro insurer or HMO has the necessary compensation and other cost information that is needed to determine the insurer

or HMO's particular costs to comply with the proposed audit committee requirements.

Proposed new §7.88(h)(1), (3) – (4), and (10) accountant qualifications and independence requirements for certain non-exempt small or micro business insurers or HMOs. The Department's cost analysis for compliance with the proposed new §7.88(h)(1), (3) – (4), and (10) accountant qualifications and independence requirements in the Public Benefit/Cost Note portion of this proposal is equally applicable to those insurers or HMOs that qualify as small or micro businesses under the Government Code §2006.001(1) and (2). The Department has determined that pursuant to the requirements in proposed new §7.88(h)(1), (4), or (10) that ensure that an accountant is qualified and independent, a small or micro business insurer or HMO that is subject to these requirements could potentially incur significant new or additional compliance costs. These costs will depend upon such factors as (i) whether and to what extent the insurer or HMO already has implemented these requirements voluntarily or to comply with the requirements in the SOX, the Insurance Code §401.011, or laws in other states in which the insurer or HMO is authorized to conduct business; (ii) whether an insurer or HMO applies for and is granted the §7.88(h)(1) exemption to the proposed new §7.88(h)(1) accountant qualifications and independence requirements; (iii) whether an insurer or HMO applies for and is granted the §7.88(h)(6) exemption to the proposed new §7.88(h)(4) accountant qualifications and independence requirements; and (iv) whether an insurer or HMO applies for and is granted the §7.88(h)(10) exemption to the proposed new

§7.88(h)(10) accountant qualifications and independence requirements. The Department anticipates that most small and micro business insurers or HMOs that otherwise may incur significant new or additional compliance costs to rotate a lead partner or other person responsible for rendering an audited financial report or to engage a new accounting firm may choose to apply for the exemptions under proposed new §7.88(h)(1), (6), and (10). The Department anticipates that, because of the criteria specified to qualify for the exemptions, small or micro business insurers or HMOs are more likely than larger business insurers or HMOs to qualify for and be granted one or more of the exemptions under proposed new §7.88(h)(1), (6), or (10). For example, under proposed new §7.88(h)(1), the Commissioner may exempt an insurer or HMO from the prohibition that a lead partner or other person responsible for rendering an insurer or HMO's audited financial report may not act in that capacity for more than five consecutive years and may not, during the five-year period after that fifth year, render an audited financial report for the insurer or HMO or for a subsidiary or affiliate of the insurer or HMO that is engaged in the business of insurance. The Commissioner may grant this exemption if the insurer or HMO demonstrates to the Commissioner's satisfaction that the limitation's application to the insurer or HMO would be unfair because of unusual circumstances. In making the determination, the Commissioner may consider: (i) the number of partners or individuals the accountant employs, the expertise of the partners or individuals the accountant employs, or the number of the accountant's insurance clients; (ii) the premium volume of the insurer or HMO; and (iii) the number of

jurisdictions in which the insurer or HMO engages in business. Therefore, based on these criteria, the cost to comply with the five-year rotation requirement would be considered by the Commissioner in considering whether to grant an exemption. Under proposed new §7.88(h)(6), an insurer or HMO that has direct written and assumed premiums of less than $100 million in any calendar year may request an exemption from the prohibition that a n or HMO may not submit an annual audited financial report that was prepared wholly or partly by an accountant, who provides the insurer or HMO at the time of the audit certain specified other services (e.g., services related to financial information systems and actuarially oriented advisory services involving the determination of amounts recorded in the financial statements). The Commissioner may grant this exemption if the Commissioner finds that application of the prohibition would impose an undue financial or organizational hardship on the insurer or HMO. Under proposed new §7.88(h)(10), an insurer or HMO may not submit the required statutory opinion if a member of the board, the president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for the insurer or HMO was employed by the accountant and participated in the audit of that insurer or HMO during the one-year period preceding the date on which the most current statutory opinion is due. An insurer or HMO may apply to the Commissioner for an exemption from these requirements on the basis of unusual circumstances. The Commissioner would have the discretion to determine that unduly burdensome cost factors for a small or micro business insurer or HMO could constitute an unusual

circumstance. A small or micro business insurer or HMO that applies for and is granted all three of the §7.88(h)(1), (6), or (10) exemptions will not incur any costs to comply with the accountant qualifications and independence requirements in proposed new §7.88(h)(1), (4), and (10). Instead, this small or micro business insurer or HMO would incur only the minimal costs to comply with exemption requirements in proposed new §7.88(h)(1), (2), (6), (10), and (12).

If a small or micro business insurer or HMO does not apply for or receive one or more of the exemptions under proposed new §7.88(h)(1), (6), or (10), the small or micro business insurer or HMO could potentially incur significant new or additional costs (i) to rotate a lead partner or other person responsible for rendering an audited financial report to comply with the accountant qualifications and independence requirements in proposed new §7.88(h)(1) or (ii) to replace their existing independent accounting firm to comply with the accountant qualifications and independence requirements in proposed new §7.88(h)(1), (4) or (10). Whether a small or micro business insurer or HMO incurs significant new or additional compliance costs will depend, in part, on whether the small or micro business insurer or HMO already is in compliance with proposed new §7.88(h)(1), (4), and (10) accountant qualification or independence requirements, either on a voluntary basis or to comply with state or federal requirements. The Department anticipates that the majority of small or micro business insurers or HMOs will not incur these additional or new significant costs because most of these insurers or HMOs will already be in compliance with proposed new

§7.88(h)(1), (4), and (10) requirements, either on a voluntary basis or to comply with state or federal requirements.

The Department anticipates that some, mostly non-public small or micro business insurers or HMOs, that (i) are not already compliant with the new accountant qualifications and independence in proposed new §7.88(h)(1) and (ii) do not apply or receive an exemption under proposed new §7.88(h)(1) will need to rotate their lead partner or other qualified person or replace their existing lead independent accounting firm for the audit to comply with the proposed new §7.88(h)(1) five-year rotation requirements. This will be necessary for the preparation and filing of the audited financial reports beginning with the report for calendar year 2010. A small or micro business insurer or HMO required to rotate the lead partner or engage a new independent accounting firm to comply with proposed new §7.88(h)(1) may incur significant costs resulting from any additional compensation needed by the new lead partner or new independent accounting firm to familiarize itself with the insurer or HMO's operations, financial records and condition, and accounting records and systems. As discussed in the Public Benefit/Cost Note part of this proposal, the total probable new or additional costs for each small or micro business insurer or HMO to rotate a lead partner or other qualified person or to replace its existing independent accounting firm with a new independent accounting firm will vary substantially depending on such factors as (i) past and existing accounting or financial irregularities, deficiencies, weaknesses, exceptions, or unique practices; (ii) the complexity of the insurer's or HMO's business; (iii) the sophistication, reliability, and adequacy

of its financial reporting processes, internal controls, accounting systems; and (iv) the qualifications and experience of the insurer's or HMO's staff.

Also, the Department anticipates that some mostly non-public small and micro insurers or HMOs that do not qualify or that do not apply for an exemption under proposed new §7.88(h)(6) will need to: (i) replace their existing lead independent accounting firm for the preparation and filing of the insurers or HMOs' required audited financial reports; or (ii) continue using their existing lead independent accounting firm for the audit but stop receiving any services from the independent accounting firm that are prohibited under proposed §7.88(h)(4) if that accounting firm is going to prepare the audited financial reports for the insurers or HMOs beginning with the report covering calendar year 2010. Additionally, the Department anticipates that some mostly non-public small and micro insurers or HMOs that do not qualify or that do not apply for an exemption under proposed new §7.88(h)(10) will need to replace their existing lead independent accounting firm to prepare and file the insurers' and HMOs' audited financial reports beginning with the report for calendar year 2010 in order to comply with proposed new §7.88(h)(10).

Furthermore, as discussed in detail in the Public Benefit/Cost Note part of the proposal, there are also mitigating cost factors for insurers or HMOs of all sizes, including small and micro business insurers or HMOs. These include offset or mitigation in compensation costs after the new independent accounting firm's familiarization period. At this time, the independent accounting firm will be able to prepare the audited financial reports more efficiently and in a shorter time

period due to the firm's greater knowledge of and familiarity with the small or micro business insurer or HMO being audited.

Additionally, the Department has determined that there are several factors unique to small and micro business insurers or HMOs that will lessen the adverse economic impact of proposed §7.88(h)(1), (3) - (4), and (10) on these insurers or HMOs. For example, the Department generally anticipates that the cost of compliance with proposed new §7.88(h)(1), (3) - (4), and (10) will be lower for small or micro business insurers or HMOs compared to larger insurers or HMOs. The Department anticipates small or micro business insurers or HMOs typically will be able to rotate a new lead partner or engage a new independent accountant at lower relative expenses compared to the expenses incurred by larger insurers or HMOs. Additionally, the Department anticipates that small and micro business insurers or HMOs often will have greater flexibility in terms of the number and types of independent accountants and independent accounting firms that are available. Further, the Department anticipates that independent accountants generally charge small and micro insurers or HMOs less than what they charge larger insurers or HMOs. However, as with larger insurers or HMOs, each small or micro insurer or HMO has the necessary cost information needed to determine the insurer or HMO's particular costs to comply with the proposed new §7.88(h)(1), (3) - (4), and (10) accountant qualifications and independence requirements.

Consideration of Regulatory Alternatives. Section 2006.002(c)(2) requires a state agency, before adopting a rule that may have an adverse

economic effect on small businesses, to prepare a regulatory flexibility analysis that includes the agency's consideration of alternative methods of achieving the purpose of the proposed rule. Section 2006.002(c-1) of the Government Code requires that the regulatory analysis "consider, if consistent with the health, safety, and environmental welfare of the state, using regulatory methods that will accomplish the objectives of applicable rules while minimizing adverse impacts on small businesses."

In accordance with the Government Code §2006.002(c-1), the Department has considered other regulatory methods to accomplish the objectives of proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), and (k)(6) audit committee requirements and the proposed new §7.88(h)(1), (3) – (4), and (10) accountant qualifications and independence requirements that will also minimize any adverse economic impact on the estimated 25 – 50 insurers or HMOs that qualify as small or micro businesses under the Government Code §2006.001(1) and (2) and are required to comply with these proposed new requirements.

Proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(1), (4), and (7) – (10), and (k)(6) are authorized by the following Insurance Code statutes: Chapter 401, Subchapter A, Chapter 404, Subchapter A, Chapter 441, and §§843.157 and 843.406 Section 401.002 states that the primary purpose of Chapter 401, Subchapter A is to require an annual audit by an independent accountant of the financial statements reporting the financial condition and the results of operations of each insurer or HMO. Further, pursuant to §§401.011 - 401.014, the Commissioner has the responsibility to ensure the independence of accountants

engaged by insurers or HMOs to prepare the statutorily required annual audited financial reports. Proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(1), (4), and (7) – (10), and (k)(6) primarily implement and clarify the Insurance Code Chapter 401, Subchapter A, by incorporating best practice standards and elements of SOX relating to accountant qualifications and independence, corporate governance, and internal control over financial reporting. These standards and elements are modeled after and consistent with the current requirements in the NAIC's revised Model Audit Rule. The primary objective of proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(1), (4), and (7) – (10), and (k)(6) is to improve the Department's surveillance of the financial condition of insurers or HMOs by (i) enhancing the accuracy and reliability of audited financial reports prepared and filed with the Commissioner; and (ii) ensuring the independence and qualifications of independent accountants engaged by insurers or HMOs to prepare and file the audited financial reports, in accordance with the Insurance Code §§401.011 401.013. Also, proposed new §7.88(b)(3) provides that an insurer or HMO establish an audit committee specifically for the purpose of "overseeing the accounting and financial reporting processes of an insurer or HMO or group of insurers or HMOs and audits of financial statements of the insurer or HMO or group of insurers or HMOs." Furthermore, the Department anticipates based on information from the NAIC that most, if not all, other states either have or will soon adopt similar requirements modeled after the NAIC's Model Audit Rule, effective beginning with audits of 2010 financial statements. Thus, insurers or HMOs authorized in Texas that are licensed or authorized to conduct the

business of insurance in another state will be expected to comply with similar audit committee requirements in calendar year 2010 in order to comply with the other state's laws.

Also, proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(1), (4), and (7) – (10), and (k)(6) are necessary to implement or supplement several financial solvency regulatory statutes. The Commissioner is required to protect insureds, enrollees, creditors, and the public against an insurer or HMO becoming insolvent, delinquent, or in a condition that renders the continuance of its business hazardous to its insureds, enrollees or creditors, or to the public, regardless of the size of the insurer or HMO, as contemplated under the Insurance Code Chapters 404, 441, and 843. The legislative intent of §§404.003 - 404.005, 404.051 - 404.053, 441.004 – 441.005, 441.051 - 441.053, 441.101 – 441.105, 843.157, and 843.406 is to ensure the financial solvency of an insurer or HMO, regardless of size, for the protection of the economic interests of all policyholders and enrollees and not just the economic interests of those policyholders and enrollees insured by large insurers or HMOs. Section 404.005(a) authorizes the Commissioner to establish (i) uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public and (ii) standards for evaluating the financial condition of an insurer. Chapter 441 addresses the prevention of insurer delinquencies. Section 441.001(e) sets forth the purpose of Chapter 441: (i) provide for the rehabilitation and conservation of insurers by authorizing and requiring supervision and conservatorship by the Commissioner; (ii) authorize

action to determine whether an attempt should be made to rehabilitate and conserve an insurer; (iii) avoid, if possible and feasible, the necessity of placing an insurer under temporary or permanent receivership; (iv) provide for the protection of an insurer's assets pending determination of whether the insurer may be successfully rehabilitated; and (v) alleviate concerns regarding insurance and insurers. Section 441.005 authorizes the Commissioner to adopt reasonable rules as necessary to implement and supplement Chapter 441 of the Insurance Code (Supervision and Conservatorship). Section 843.157 provides that the rehabilitation, liquidation, supervision, or conservation of a health maintenance organization must be treated as a rehabilitation, liquidation, supervision, or conservation of an insurer and be conducted under the supervision of the Commissioner under Chapters 441 or 443, as appropriate. Section 843.406 authorizes the Commissioner to establish, in a manner consistent with the purposes of §843.406, (i) uniform standards and criteria for early warning that the continued operation of a health maintenance organization could be hazardous to the health maintenance organization's enrollees or creditors or the public; and (ii) standards for evaluating the financial condition of a health maintenance organization. Therefore, the requirements in proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(1), (4), and (7) – (10), and (k)(6) are important, cost-effective tools for the Commissioner to accomplish the regulatory responsibilities mandated under Chapters 404, 441, and 843. These proposed requirements are expected to improve an insurer's or HMO's corporate governance, internal controls over financial reporting, and independent

accountant's qualifications and independence. All of these improvements will, in turn, result in better internal controls and accounting systems, as well as in financial books and records, financial statements, and audited financial reports that are more likely to be complete, current, reliable, and reflect the true and correct financial condition of an insurer or HMO. The Commissioner relies on the accuracy and completeness of the insurer's or HMO's books and records, its financial statements, the audited financial report and the independent accountant's opinion in monitoring and regulating the insurer's or HMO's financial position and operations. Thus, it is crucial that the independent accountant be completely independent from the insurer or HMO in expressing an opinion on the financial statement in an audited financial report filed under Chapter 401, Subchapter A. For example, an accountant that is more highly qualified and truly independent will be more likely to conclude in an audited financial report, when appropriate, that an insurer or HMO is operating in a hazardous financial condition compared to an accountant that is less qualified and independent. Thus, the requirements in proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(1), (4), and (7) – (10), and (k)(6) will facilitate the Department's and the insurer's or HMO's ability to actively monitor an insurer's or HMO's financial condition and operations, and to detect and take timely, appropriate action to address situations in which a insurer or HMO is in a financial condition or is operating or conducting business in a manner that would render further transaction of business in this state hazardous to the policyholders, enrollees, or creditors of the insurer or HMO or to the public.

Even so, the Department carefully considered other regulatory methods to accomplish the objectives of the statute and the proposal and that would at the same time minimize any adverse economic impact on insurers or HMOs that qualify as small or micro businesses under the Government Code §2006.001(1) and (2). These regulatory alternatives are: (i) not adopting the proposed audit committee requirements and accountant qualifications and independence requirements and relying on the statues only; (ii) exempting all small or micro business insurers or HMOs from the proposed audit committee requirements; and (iii) exempting all small or micro business insurers or HMOs from the proposed independent accountant requirements. The following discusses the Department's analysis of these three alternative regulatory methods.

(i) Not adopting proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(1), (4), and (7) – (10), and (k)(6). The Department determined that there are at least three reasons why it is necessary to adopt the proposed audit committee requirements and accountant qualifications and independence requirements in §7.88(b)(3), (c)(3), (d)(5), (h)(1), (4), and (7) – (9), and (k)(6). First, while insurers or HMOs that are required to prepare and file audited financial reports would still be statutorily required to file accurate, reliable financial statements, and engage independent and qualified accountants, these insurers or HMOs would have no regulatory guidance on accountant independence and corporate governance standards that other states have adopted for conducting business in those states. The result would be that each individual insurer or HMO, regardless of size, would have greater discretion in determining their accountant's independence

and qualifications and the manner of oversight of the insurer's or HMO's accounting and financial reporting processes and audits of the financial statements. This, in turn, could result in a less reliable and consistent means of ensuring accountant independence and qualifications and reliability, completeness, and accuracy of financial statements. Ultimately, this could adversely impact insureds and enrollees by making it less likely that the audit committees, boards of directors, and independent accountants engaged by the insurers or HMOs will identify, understand, and take appropriate, timely action to correct potentially hazardous financial conditions, including preventing, detecting, and rectifying fraudulent or mistaken insurer or HMO transactions, books and records, and financial reporting. Second, it is the Department's position that the failure of an insurer or HMO to utilize an audit committee that complies with the proposed requirements, or to ensure that their independent accountant is qualified or independent, may increase the risk that an insurer or HMO could potentially operate in a hazardous financial condition, or be in a condition that renders the continuance of its business hazardous to its insureds, enrollees, creditors, or to the public. This could ultimately result in the insurer or HMO becoming insolvent or delinquent. Under the Insurance Code Chapters 404, 441, and 843, the Commissioner is required to protect insureds, enrollees or creditors, and the public against an insurer or HMO becoming insolvent, delinquent, or in a condition that renders the continuance of its business hazardous to its insureds, enrollees or creditors, or to the public, regardless of the size of the insurer or HMO. As previously stated, proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(1), (4),

and (7) – (10), and (k)(6) provide necessary guidance and tools for (i) ensuring the qualifications and independence of the independent accountants engaged by insurers or HMOs and (ii) for improving corporate governance standards and criteria for conducting business in Texas. Third, adoption of the 2006 updates to the NAIC's Model Audit Rule is an NAIC accreditation requirement for each state, effective in calendar year 2010. Therefore, adoption of the 2006 updates is required for the Department to maintain its NAIC accreditation after January 1, 2010. Recent polls of the various state insurance regulators indicate that all 50 states either have adopted or plan to adopt the 2006 updated requirements prior to or during calendar year 2010. Thus, if any of the small and micro business insurers or HMOs are licensed and operating in other states, these insurers or HMOs likely would be subject to requirements similar to those proposed in §7.88(b)(3), (c)(3), (d)(5), (h)(1), (4), and (7) – (10), and (k)(6).

The objective and intent of the pertinent statutes include (i) requiring an annual audit by an independent, qualified accountant of the financial statements needed to report the financial condition and the results of operations of each insurer or HMO; (ii) maintaining solvent insurers or HMOs and thereby protecting insureds, enrollees, creditors, and the public from economic harm from insurers or HMOs operating in hazardous financial conditions; and (iii) providing regulators with information necessary to discharge their solvency regulatory duties. Therefore, based on the preceding factors, the Department rejected the approach of not adopting the proposed audit committee requirements and accountant qualifications and independence requirements because it would not

fully accomplish the objective of the statutes and the rule proposal and, therefore would not be consistent with legislative intent.

(ii) Exempting small and micro business insurers or HMOs from the proposed audit committee requirements. As provided in proposed new §7.88(c)(3), the purpose of the audit committee requirements is to oversee the accounting and financial reporting processes of an insurer or HMO or group of insurers or HMOs and audits of financial statements of the insurer or HMO or group of insurers or HMOs. The Department determined that there are at least three reasons why it is necessary to not exempt small and micro business insurers or HMOs from the proposed audit committee requirements in §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), and (k)(6). First, while this alternative would avoid any potentially adverse economic effect of these proposed requirements on small or micro business insurers or HMOs, it would also result in these insurers or HMOs having greater discretion in how accountant independence and qualifications are determined and how and to what extent the accounting and financial reporting processes of the insurer or HMO and audits of the financial statements are monitored and overseen. This could result in a less reliable or consistent means of ensuring accountant independence and qualifications and reliability and accuracy of financial statements by small or micro business insurers or HMOs. This disparate application of the proposed audit committee requirements could negatively impact the insureds and enrollees of these small and micro insurers or HMOs while the insureds and enrollees of larger insurers or HMOs would not be subject to such negative impact. This

negative impact could include failure to identify and timely correct potentially hazardous financial conditions that could, in turn, result in an insolvent insurer or HMO, or an even larger insolvency for an insurer or HMO in terms of the size of the shortfall between an insurer or HMO's assets and its obligations owed to policyholders and other creditors. Second, because there are statutes that already provide certain exemptions, as well as prohibit certain exemptions, that may pertain to small and micro insurers or HMOs, exemption from proposed §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), and (k)(6) would greatly expand the number of exemptions for small and micro insurers or HMOs. This would result in small and micro business insurers or HMOs being exempt from significant financial regulatory protective measures in a manner inconsistent with the intent of financial solvency statutes. For example, under the Insurance Code §401.006, insurers or HMOs with less than $1 million in direct premiums written in this state during a calendar year can qualify for an exemption to the independent audit requirements in the Insurance Code Chapter 401, Subchapter A. Additionally, under §401.008(c), the Commissioner is prohibited from granting a hardship exemption under §401.008(a) and (b) for an insurer or HMO that is not eligible for a exemption under §401.006 or §401.007 if: (i) the exemption would diminish the Department's ability to monitor the financial condition of the insurer or HMO; or (ii) during the five-year period preceding the date the application for the exemption is made the insurer or HMO has been placed under supervision, conservatorship, or receivership; has undergone a change in control; or has been subject to a significant number of complaints; (iii) the insurer or HMO has been

identified by the Department as troubled; (iv) the insurer or HMO has been or is the subject of a disciplinary action by the Department; or (v) the insurer or HMO is not complying with the law or with a rule adopted by the Commissioner. The statutory prohibition that the Commissioner not grant a hardship exemption if the exemption would diminish the Department's ability to monitor the insurer or HMO's financial condition is particularly significant. It demonstrates the paramount importance placed by the Legislature on the Commissioner's and Department's responsibilities to protect insureds, enrollees, creditors, and the public against an insurer or HMO becoming insolvent, delinquent, or in a condition that renders the continuance of its business hazardous to its insureds, enrollees or creditors, or to the public. Third, adoption of the 2006 updates to the NAIC's Model Audit Rule is an NAIC accreditation requirement for each state, effective in calendar year 2010. Therefore, adoption of the 2006 updates is required for the Department to maintain its NAIC accreditation after January 1, 2010. Recent polls of the various state insurance regulators indicate that all 50 states either have adopted or plan to adopt the updated NAIC requirements prior to or during calendar year 2010. Thus, if any of the small and micro business insurers or HMOs are licensed and operating in other states, these insurers or HMOs likely would be subject to requirements similar to those proposed in §7.88(b)(3), (c)(3), (d)(5), (h)(7) – (9), and (k)(6). The Department, therefore, rejected the approach of authorizing broader exemptions to the audit committee requirements than are authorized under §401.006 and §401.008 of the Insurance Code.

(iii) Exempting small and micro business insurers or HMOs from the proposed accountant qualification and independence requirements. The Department determined that there are at least three reasons why it is necessary to not totally exempt small and micro business insurers or HMOs from the proposed accountant qualification and independence requirements in §7.88(h)(1), (4), and (10). First, outright exemption from these requirements would remove any need for any small or micro business insurer or HMO to apply for any of the applicable exemptions already provided in proposed new §7.88(h)(1), (6), and (10). It would also remove the discretion of the Commissioner to consider each requested exemption on a case by case basis. It would, thereby, destroy the proposed regulatory scheme that ensures the careful consideration by the Commissioner of each insurer or HMO based on its own financial conditions and operating circumstances. Second, new §7.88(h)(1), (6), and (10) as proposed contain exemptions that will mitigate the economic impact of the proposed new §7.88(h)(1), (4), or (10) requirements respectively for any insurer or HMO that applies for and is granted one or more of the exemptions. These three exemptions are substantially similar to the ones adopted by the NAIC in its most currently updated Model Audit Rule. Under proposed new §7.88(h)(1), an insurer or HMO can apply for and be granted an exemption from the §7.88(h)(1) lead audit partner rotation limitation if the Commissioner determines that the limitation's application would be unfair because of unusual circumstances. Proposed new §7.88(h)(1) specifically provides that the Commissioner may consider (i) the premium volume of the insurer or HMO; (ii)

the number of jurisdictions in which the insurer or HMO engages in business; and (iii) the number of partners or individuals the accountant employs, the expertise of the partners or individuals the accountant employs, or the number of the accountant's insurance clients. Under proposed new §7.88(h)(6), an insurer or HMO that has direct written and assumed premiums of less than $100 million in any calendar year may apply for and be granted an exemption from the accountant qualification and independence requirements in proposed new §7.88(h)(4) if the Commissioner finds that compliance with proposed new §7.88(h)(4) would impose an undue financial or organizational hardship on the insurer or HMO. Under proposed new §7.88(h)(10), an insurer or HMO can apply for and be granted an exemption from the proposed new §7.88(h)(10) independent accountant requirements on the basis of unusual circumstances. Based upon the criteria specified in this proposal for each of these exemptions, the Department anticipates that small or micro business insurers or HMOs are more likely to apply for and qualify for one or more of the partial exemptions to the proposed new accountant qualification and independence requirements. The Department anticipates that a small or micro business insurer or HMO that is granted an exemption under proposed new §7.88(h)(1), (6), or (10) may be able to avoid any potentially adverse economic impact, and instead, incur only routine costs associated with the exemption request and approval filing requirements. This is because the small or micro business insurer or HMO that is granted one or more exemptions under proposed new §7.88(h)(1), (6), or (10) may not need to rotate its lead audit partner or find a new independent accounting firm to

replace its existing independent accounting firm in order to comply with proposed new §7.88(h). Third, compliance costs to apply for the exemptions in proposed §7.88(h)(1), (6), and (10) are minimal and would not impose an economic hardship on small and micro business insurers or HMOs. These costs are discussed in detail in the Public Benefit/Cost Note part of this proposal.

The Department rejected the alternative regulatory approach of exempting all small and micro business insurers or HMOs outright from the accountant qualification and independence requirements in the proposal because the Department determined that the proposal contains sufficient exemptions or exceptions to the independent accountant requirements for small and micro business insurers or HMOs and expanding the number of exemptions is inconsistent with the objective and intent of the statutory financial solvency regulations.

No viable alternative regulatory methods. Based on the foregoing analysis, the Department has determined that there are no viable alternative regulatory methods to the audit committee and accountant qualifications and independence requirements contained in this proposal that can be applied to small and micro business insurers or HMOs that will achieve the purpose of these requirements and also reduce compliance costs for such insurers or HMOs. The Department has determined that the audit committee and accountant qualification and independence requirements in proposed new §7.88(b)(3), (c)(3), (d)(5), (h)(1), (4), and (7) – (10), and (k)(6) are the most cost-effective means of ensuring the accuracy and reliability of insurer or HMO

financial statements and audited financial reports that must be filed with the Commissioner for purposes of solvency regulation. Adequate solvency regulation is necessary for insurers or HMOs of all sizes, not just those insurers or HMOs that do not meet the definitions of small and micro businesses in the Government Code §2006.001(1) and (2). Furthermore, the proposed requirements are consistent with and modeled after the SOX and the 2006 updates to the NAIC's Model Audit Rule, which are expected to be adopted by all 50 states prior to or during calendar year 2010. The proposed new requirements are designed to enhance regulatory oversight without undue burden on the insurance industry and to obtain the biggest public benefit at the lowest cost of compliance. Moreover, as explained in the Introduction of this proposal, the NAIC/AICPA Working Group, in collaboration with industry representatives, has drafted an implementation guide to help in the application of and compliance with the proposed new requirements. The implementation guide being developed by the NAIC is expected to be an informational appendix to the NAIC Accounting Practices and Procedures Manual (AP&P Manual). The inclusion of the implementation guide is expected to reduce the costs and time of implementation by insurers or HMOs subject to the requirements in the proposed new rule. This should also greatly assist small and micro business insurers or HMOs in reducing compliance costs and time.

Proposed new §7.88(k)(3) and (8) and (m)(2) – (8). The Department estimates that the Commissioner will likely direct no more than one or two small or micro business insurers or HMOs to comply with proposed new §7.88(k)(3) or

(m)(2) during the first five years that the proposal is in effect. Pursuant to proposed new §7.88(k)(2)(C), except as provided in proposed new §7.88(k)(3), insurers or HMOs with less than $300 million or more in direct written and assumed premium in the preceding calendar year are not required to comply with the audit committee member requirements in proposed new §7.88(k)(2). Under proposed new §7.88(k)(3), the board of directors of insurers or HMOs, including small or micro business insurers or HMOs, may be required by the Commissioner to enact improvements to the independence of the audit committee membership because the insurer or HMO: (i) is in a risk-based capital action level event, as described by or provided in the Insurance Code Chapters 822, 841, 843, or 884 or rules adopted thereunder, including §7.402; (ii) meets one or more of the standards of an insurer or HMO considered to be in hazardous financial condition as described by or provided in the Insurance Code Chapters 404, 441, or 843 or rules adopted thereunder, including §§8.1 - 8.4 and 11.810; or (iii) otherwise exhibits qualities of a troubled insurer or HMO. As provided in proposed new §7.88(m)(2), insurers or HMOs of any premium volume size, including small or micro business insurers or HMOs, may be required by the Commissioner to file the internal control over financial reporting report because the insurer or HMO is in any risk-based capital level event or meets one or more of the standards of an insurer or HMO considered to be in hazardous financial condition as described by and provided in the Insurance Code Chapters 404, 441, 822, 841, 843, or 884 or rules adopted thereunder, including §§7.402, 8.1 - 8.4, and 11.810. As previously stated, the Department

estimates that the Commissioner will likely direct no more than one or two of the estimated 25 - 50 small or micro business insurers or HMOs either to enact improvements to the independence of the insurer or HMO's audit committee membership or to prepare and file a report on the insurer or HMO's internal control over financial reporting. The §7.88(k)(3) authority would be exercised when a small or micro business insurer or HMO (i) triggers a risk-based capital level event as described by or provided in the Insurance Code Chapters 822, 841, 843, or 884 or rules adopted thereunder, including §7.402, meets one or more of the hazardous financial condition standards in the Insurance Code Chapters 404 or 441, or rules adopted thereunder, including §§8.1 - 8.4, and 11.810, or otherwise exhibits qualities of a troubled insurer or HMO; and (iii) is subject to an order, directive, or other requirement of the Commissioner to enact improvements to the independence of the insurer or HMO's audit committee membership pursuant to the Commissioner's authority under the Insurance Code §§404.003, 404.051 – 404.053, 441.053, 822.211, 841.205 - 841.207, 843.157, 843.404, 843.406, and 884.206, or rules adopted thereunder, including §§7.402, 8.1 - 8.4, and 11.810. The §7.88(m)(2) authority would be exercised when a small or micro business insurer or HMO (i) triggers a risk-based capital level event, or meets one or more of the hazardous financial condition standards in the Insurance Code Chapters 404, 441, 822, 841, 843, or 884, or rules adopted thereunder, including §§7.402, 8.1 - 8.4, and 11.810; and (ii) is subject to an order, directive, or other requirement of the Commissioner to prepare and file a report on the insurer or HMO's internal control over financial reporting issued

pursuant to the Commissioner's authority under the Insurance Code §§404.003, 404.051 – 404.053, 441.053, 822.211, 841.205 - 841.207, 843.157, 843.404, 843.406, and 884.206, or rules adopted thereunder, including §§7.402, 8.1 - 8.4, and 11.810. As a result, the Department does not anticipate that the vast majority of small or micro business insurers or HMOs will incur additional, potentially significant costs to comply with the management's report of internal control over financial reporting requirements in proposed new §7.88(m)(2) and the audit committee member independence requirements in proposed new §7.88(k)(3), such as annual board member compensation, fees for attending board meetings, fees for serving on committees, and stock options.

Under proposed new §7.88(k)(3) and (8), the one or two small or micro business insurers or HMOs that could be directed by the Commissioner under proposed new §7.88(k)(3) to enact improvements to the independence of the insurer or HMO's audit committee membership potentially would incur significant costs to enact improvements to the independence of the audit committee membership, including adding an independent member or members to their board of directors and audit committees. Such costs would also be attributable to the proposed §7.88(k)(8) requirement of what constitutes "independent" for purposes of §7.88(k). Under proposed new §7.88(k)(8), a member of the audit committee may not, other than in the person's capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory, or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary of the entity. Proposed new §7.88(k)(8)

further provides that to the extent of any conflict with a statute requiring an otherwise non-independent board member to participate in the audit committee, the other statute prevails and controls, and the member may participate in the audit committee unless the member is an officer or employee of the insurer or HMO or an affiliate of the insurer or HMO. The Department's cost analysis and resulting estimated compliance costs for insurers or HMOs outlined in the Public Benefit/Cost Note part of this proposal are equally applicable to small and micro businesses. As discussed, insurers or HMOs will be expected to incur one-time expenses to recruit and evaluate the new member or members as well as annual costs to compensate this member or members to carry out the required audit committee functions. The actual total costs to compensate and retain the new independent audit committee member or members will vary substantially depending on such factors as (i) the type of the small or micro business insurer or HMO; (ii) the location of its offices; (iii) the amount and complexity of its business; and (iv) the small or micro business insurer or HMO's particular business practices related to the compensation of directors, including the various types of compensation paid to directors, such as annual board member compensation, fees for attending board meetings, fees for serving on committees, and stock options. The insurer's or HMO's actual cost to increase compensation to existing board or audit committee members or to retain a new independent audit committee member or members are known to the insurer or HMO. As a result, an individual insurer or HMO is able to determine its particular cost to comply with proposed new §7.88(k)(3) and (8). Regardless of the amount

of these costs, the Department anticipates that they may be mitigated or offset in instances where a new independent board member (or members) is replacing an existing non-independent member (or members). In effect, the compensation costs that are saved by the removal from the board of a non-independent member or members can be used to compensate the new independent member or members replacing the removed non-independent member or members. This may significantly offset the total compensation costs that would be incurred for the new independent member or members.

Under proposed new §7.88(m)(2) and (5) – (8), the one or two small or micro business insurers or HMOs that could be directed by the Commissioner to comply with the management's report of internal control over financial reporting requirements in proposed new §7.88(m)(2) and (5) – (8), potentially would incur significant costs to prepare and submit the report to the Commissioner. These potential significant costs could have an adverse economic impact on the one or two small or micro business insurers or HMOs. Such costs would also be attributable to the requirements in proposed §7.88(m)(5) – (8) which specify required documentation and opinions, disclosures, prohibitions, and permissible discretion pertaining to the preparation and finalization of the management's report of internal control over financial reporting. The Department's cost analysis and resulting estimated compliance costs for proposed §7.88(m)(2) and (5) – (8) outlined in the Public Benefit/Cost Note part of this proposal are equally applicable to small and micro businesses. As discussed, most insurers or HMOs, including small or micro business insurers or HMOs, required to prepare

and submit a report of internal control over financial reporting to the Commissioner under proposed new §7.88(m)(2) and (5) - (8) will assemble a team of staff accounting and management professionals who have knowledge of the insurer or HMO, as well as of its books, records, accounting systems, and internal control structure. The Department anticipates that the size of the team assembled by a small or micro business insurer or HMO will vary considerably based on a wide range of factors, including (i) the complexity of the insurer's or HMO's operations; (ii) the adequacy and level of complexity of the insurer's or HMO's systems of internal controls over financial reporting; (iii) the relative strength or weakness of the insurer's or HMO's electronic systems, including accounting systems, premiums systems, policy administration systems, underwriting systems, claims systems, reinsurance systems and investment systems; (iv) whether a robust enterprise risk management systems exists; (v) the adequacy and competency of the insurer's or HMO's accounting staff; (vi) the general corporate culture, concerning, for example, risk tolerance and adherence to accepted industry best practices; (vii) whether a relatively minor deficiency, a significant deficiency, or a material weakness is identified; and (viii) whether remediation efforts are necessary to address material weaknesses in the internal control structure. Therefore, the Department anticipates that the actual total costs to an individual small or micro business insurer or HMO will primarily relate to the number, type, and wages of staff and the number of hours required for each staff member necessary to perform the functions required to comply with the proposed requirements for the management's report of internal control over

financial reporting in §7.88(m)(2) and (5) – (8). These functions include planning, analysis, document preparation, remediation efforts, and subsequent monitoring efforts pertaining to the report of internal control over financial reporting. Generally, an insurer or HMO, including a small or micro business insurer or HMO, will be required to perform a comprehensive review and analysis of its internal control over financial reporting and perform the §7.88(m)(5) – (8) functions over their entire control structure as a prerequisite to preparing the report required by proposed new §7.88(m)(2). The small or micro business insurer or HMO may elect to utilize external accountants and consultants to assist in the preparation of the required management report. If this option is elected, additional compliance costs will be incurred. However, because there is no requirement that external accountants and consultants be used in the preparation of the reports required pursuant to proposed new §7.88(m)(2) and (5) – (8), the small or micro business insurer or HMO has complete control over whether to utilize this option and thus incur these costs. Accordingly, the Department anticipates that the estimated one or two small or micro business insurers or HMOs typically will utilize their own staff to prepare the required management report on internal controls. Therefore, the individual small or micro insurers or HMOs have knowledge of the compensation and other cost information that is needed to determine their particular costs to prepare the required management's report of internal control over financial reporting. Additionally, under proposed new §7.88(m)(7), the management of any small or micro business must prepare a written memorialization of the basis or thought

process used in deriving the opinions required by proposed new §7.88(m)(5). Proposed new §7.88(m)(7) does not expressly require that an insurer or HMO's management follow a specific or prescribed protocol in documenting the basis for the opinions. Instead, proposed new §7.88(m)(8) provides that an insurer or HMO's management has discretion regarding the nature of the internal control framework used and the nature and extent of the §7.88(m)(7) documentation, in order to form its opinions in a cost-effective manner and may include an assembly of or reference to existing documentation. The Department anticipates that the estimated one or two small or micro business insurers or HMOs will typically elect to exercise the discretion provided under proposed new §7.88(m)(8) in order to lower the costs of compliance with proposed new §7.88(m)(5) and (7). Moreover, the Department anticipates that the same team of staff, or a subset of that team, will prepare the §7.88(m)(7) documentation for the basis of the opinions required by proposed new §7.88(m)(5). Accordingly, the Department anticipates that the costs of compliance with proposed §7.88(m)(7) will primarily relate to the wages attributable to these employees and the amount of time that is required to produce this documentation. These wage expenses on an hourly basis and other cost factors have been previously detailed in the description of the costs to comply with proposed new §7.88(m)(2) and (5) in the Public Benefit/Cost Note part of this proposal. The Department, however, anticipates that the costs for compliance with proposed new §7.88(m)(7) by small and micro business insurers or HMOs will overall be less than the costs required for larger insurers or HMOs. The amount of time that is

required to prepare the documentation required by proposed new §7.88(m)(7) will vary based on the same factors that have been previously detailed for compliance with proposed new §7.88(m)(2) and (5) – (8) in the Public Benefit/Cost Note part of this proposal. In summary, these factors concern whether an insurer or HMO already has internal controls in place or whether a new internal control(s) is required.

As previously discussed, most insurers or HMOs, including small or micro business insurers or HMOs, required to prepare and submit a report of internal control over financial reporting to the Commissioner under proposed new §7.88(m)(2) and (5) - (8) will assemble a team of staff accounting and management professionals who have knowledge of the insurer or HMO, as well as of its books, records, accounting systems, and internal control structure. The Department anticipates that a larger insurer or HMO is much more likely to need a large team of staff than a small or micro business insurer or HMO. This is because a smaller, less complex insurer or HMO will have less work to be done to ensure the internal controls are adequate. As a result, the Department anticipates that a small or micro business insurer or HMO will often be able to assemble a smaller team of staff professionals to prepare and submit a report of internal control over financial reporting to the Commissioner compared to a larger insurer or HMO. This means that the cost of compliance for the one or two small or micro business insurers or HMOs generally will be less compared to the costs incurred by medium or large insurers or HMOs. The Department anticipates that these costs will have less of an adverse economic impact on small or micro

insurers or HMOs than on medium to large insurers or HMOs. This is because small or micro business insurers or HMOs typically will have less complex operations and business models compared to medium or large insurers or HMOs. Therefore, the Department anticipates that the internal control structure needs of a small or micro business insurer or HMO will often not be as wide-ranging in scope or as complex as the needs of a medium or large insurer or HMO, which often require a larger number of internal controls and/or more sophisticated systems of internal control. As a result, the Department anticipates that the amount of insurer or HMO staff time and resources (detailed in the Public Benefit/Cost Note part) to prepare and submit a report of internal control over financial reporting under proposed new §7.88(m)(2) and (5) - (8) will generally be less for small or micro business insurers or HMOs than for medium or large insurers or HMOs.

In accordance with the Government Code §2006.002(c-1), the Department has determined that even though proposed new §7.88(k)(3) and (8) or (m)(2) and (5) – (8) may have an adverse economic effect on approximately one or two small or micro business insurers or HMOs during the first five years that the proposal is in effect, the Department is not required to prepare a regulatory flexibility analysis as required in §2006.002(c)(2) of the Government Code. Section 2006.002(c)(2) requires a state agency, before adopting a rule that may have an adverse economic effect on small businesses, to prepare a regulatory flexibility analysis that includes the agency's consideration of alternative methods of achieving the purpose of the proposed rule. Section 2006.002(c-1) of the

Government Code requires that the regulatory flexibility analysis ". . . consider, if consistent with the health, safety, and environmental and economic welfare of the state, using regulatory methods that will accomplish the objectives of applicable rules while minimizing adverse impacts on small businesses." Therefore, an agency is not required to consider alternatives that, while possibly minimizing adverse impacts on small and micro-businesses, would not be protective of the health, safety, and environmental and economic welfare of the state. For the following reasons, the Department has determined, in accordance with the Government Code §2006.002(c-1), that there are no regulatory alternatives to proposed new §7.88(k)(3) and (8) and (m)(2) and (5) – (8) that will sufficiently protect the economic interests of insurers, HMOs, and consumers and the economic welfare of the state.

First, proposed new §7.88(k)(3) and (8) and (m)(2) and (5) – (8) are necessary to implement or supplement several financial solvency regulatory statutes. The Commissioner is required to protect insureds, enrollees, creditors, and the public against an insurer or HMO becoming insolvent, delinquent, or in a condition that renders the continuance of its business hazardous to its insureds, enrollees, or creditors, or to the public, regardless of the size of the insurer or HMO, as contemplated under the Insurance Code Chapters 404, 441, and 843. The legislative intent of §§404.003 - 404.005, 404.051 - 404.053, 441.004 – 441.005, 441.051 - 441.053, 441.101 – 441.105, 843.157, and 843.406 is to ensure the financial solvency of an insurer or HMO, regardless of size, for the protection of the economic interests of all policyholders or enrollees and not just

the economic interests of those policyholders or enrollees insured by large insurers or HMOs. Section 404.005(a) authorizes the Commissioner to establish (i) uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer’s policyholders, or creditors or to the public and (ii) standards for evaluating the financial condition of an insurer. Chapter 441 addresses the prevention of insurer delinquencies. Section 441.001(e) sets forth the purpose of Chapter 441: (i) provide for the rehabilitation and conservation of insurers by authorizing and requiring supervision and conservatorship by the Commissioner; (ii) authorize action to determine whether an attempt should be made to rehabilitate and conserve an insurer; (iii) avoid, if possible and feasible, the necessity of placing an insurer under temporary or permanent receivership; (iv) provide for the protection of an insurer's assets pending determination of whether the insurer may be successfully rehabilitated; and (v) alleviate concerns regarding insurance and insurers. Section 441.005 authorizes the Commissioner to adopt reasonable rules as necessary to implement and supplement Chapter 441 of the Insurance Code (Supervision and Conservatorship). Section 843.157 provides that the rehabilitation, liquidation, supervision, or conservation of a health maintenance organization shall be treated as a rehabilitation, liquidation, supervision, or conservation of an insurer and be conducted under the supervision of the Commissioner under Chapter 441 or 443, as appropriate. Section 843.406 authorizes the Commissioner to establish, in a manner consistent with the purposes of §843.406, (i) uniform standards and criteria for early warning that

the continued operation of a health maintenance organization could be hazardous to the health maintenance organization's enrollees or creditors or the public; and (ii) standards for evaluating the financial condition of a health maintenance organization. The requirements in proposed new §7.88(k)(3) and (8) and (m)(2) and (5) – (8) are necessary for the Commissioner to accomplish the regulatory responsibilities contemplated under Chapters 404, 441, and 843, concerning an insurer or HMO in a potentially hazardous financial condition. These requirements are designed to help remedy an insurer's or HMO's existing potentially hazardous financial conditions, to prevent potentially hazardous financial conditions from occurring in the future, and to ensure an insurer or HMO is brought into and maintains compliance with all applicable laws, including solvency-related laws. The Department has determined in accordance with the Government Code §2006.002(c-1) that there are no regulatory alternatives to these financial regulatory statutes that will sufficiently protect insureds, enrollees, creditors, and the public against an insurer or HMO becoming insolvent, delinquent, or in a condition that renders the continuance of its business hazardous to its insureds, enrollees, or creditors, or to the public.

Second, the requirements in proposed new §7.88(k)(3) and (8) and (m)(2) and (5) – (8) are generally expected to improve the corporate governance, internal control over financial reporting, and independent accountant's qualifications and independence for an insurer or HMO in a potentially financial hazardous condition. In turn, these improvements will result in better internal controls and accounting systems, as well as in financial books and records,

financial statements, and audited financial reports that are more likely to be complete, current, reliable, and reflect the true and correct financial condition of the insurer or HMO. The Department has determined that there are no regulatory alternatives that would ensure the needed improvements in these internal controls and accounting systems that are necessary to sufficiently protect the economic interests of insurers, HMOs, and consumers, and the economic welfare of the state.

Third, proposed new §7.88(k)(3) and (8) require an insurer or HMO's board of directors to enact improvements to the independence of the audit committee membership as directed by the Commissioner. The Department expects that an audit committee with more independent members will more effectively, independently, and completely carry out its responsibilities relating to the appointment, compensation, and oversight of the independent accountant and the oversight of the insurer's or HMO's accounting and financial reporting processes and audits of the insurer or HMO's financial statements. Therefore, proposed new §7.88(k)(3) and (8) will help ensure that the insurer's or HMO's independent accountant is truly qualified and independent, in accordance with the applicable requirements in the Insurance Code Chapter 401, Subchapter A, including §§401.011 – 401.013, and in proposed new §7.88(b)(3), (d)(3), (h), and (k). The Commissioner relies on the accuracy and completeness of the insurer's or HMO's books and records, its financial statements, the audited financial report, and the independent accountant's opinion in monitoring and regulating the insurer's or HMO's financial position and operations. Thus, it is crucial that the

independent accountant be completely independent from the insurer or HMO in expressing an opinion on the financial statement in an audited financial report filed under the Insurance Code Chapter 401, Subchapter A. For example, an independent accountant that is more highly qualified and truly independent will be more likely to conclude in an audited financial report, when appropriate, that an insurer or HMO is operating in a hazardous financial condition as compared to an independent accountant that is less qualified and independent. The purpose of the proposed new §7.88(m)(2) and (5) – (8) requirements are to (i) require a insurer's or HMO's management to establish and maintain adequate internal controls in order to ensure the integrity and accuracy of financial books and records and financial statements; (ii) guard against fraudulent or mistaken transactions; and (iii) ensure the accuracy of annual audited financial reports. The Department has determined that there are no regulatory alternatives that will ensure the necessary audit committee and accountant independence and qualifications that are necessary for adequate and effective monitoring and regulation of the insurer's or HMO's financial position and operations. This adequate and effective monitoring and regulation is necessary to sufficiently protect the economic interests of insurers, HMOs, and consumers, and the economic welfare of the state.

In addition, §7.88(m)(8) as proposed provides flexibility to enable an insurer or HMO to comply with the requirements for the management's report of internal control over financial reporting in accordance with its own set of circumstances. Proposed §7.88(m)(8) authorizes an insurer's or HMO's

management to use its discretion as to the nature of the internal control framework used and the nature and extent of the documentation required by proposed new §7.88(m)(7), in order to form its opinion in a cost-effective manner. It further allows an insurer or HMO to include an assembly of or reference to existing documentation. This discretion will enable an insurer or HMO to keep its own individual costs of compliance as low as possible. As a result, the Department does not anticipate that there will be an adverse economic impact on small or micro business insurers or HMOs as a result of proposed new §7.88(m)(8).

5. TAKINGS IMPACT ASSESSMENT. The Department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

6. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on June 28, 2010. All comments should be submitted to Gene C. Jarmon, General Counsel and Chief Clerk, Texas Department of Insurance, Mail Code 113-2A, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comments should be submitted simultaneously to Danny Saenz, Senior Associate Commissioner,

Financial Program, Texas Department of Insurance, Mail Code 305-2A, P.O. Box 149104, Austin, Texas 78714-9104.

The Commissioner will consider the adoption of the proposed new section in a public hearing under Docket Number 2712, at 9:30 A.M. on June 24, 2010, in Room 100 at the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas 78701. Written and oral comments presented at the hearing will be considered.

7. STATUTORY AUTHORITY. The new section is proposed under the Insurance Code Chapters 32, 401, 404, 421, 441, 541, 801, 802, 822, 823, 841, 843, and 884, and §36.001. Section 32.041 requires the Department to furnish to the companies required to report to the Department the statement blanks and other reporting forms necessary for companies to comply with the filing requirements. Section 401.001 defines the terms *accountant*, *affiliate*, *health maintenance organization*, *insurer*, and *subsidiary* that are used in the Insurance Chapter 401, Subchapter A. Section 401.004(a) provides that unless exempt under the Insurance Code §§401.006, 401.007, or 401.008 and except as otherwise provided by §401.005 and §401.016, an insurer or health maintenance organization shall have an annual audit performed by an accountant, and file with the Commissioner on or before June 30 an audited financial report for the preceding calendar year. Section 401.004(b) authorizes the Commissioner to require an insurer or health maintenance organization to file an audited financial report on a date that precedes June 30 and requires the Commissioner to notify

the insurer or health maintenance organization of the filing date not later than the 90th day before that date. Section 401.004(c) allows an insurer or health maintenance organization to request an extension of the filing date for the audited financial report, under certain specified conditions, including submitting the request in writing before the 10th day preceding the filing date. Section 401.005 provides that an insurer or health maintenance organization domiciled in Canada or the United Kingdom may file the insurer's or health maintenance organization's annual statement of total business on the form filed by the insurer or health maintenance organization with the appropriate regulatory authority in the country of domicile; this is in lieu of filing the audited financial report required by the Insurance Code §401.004 and only if certain specified conditions are met. Section 401.006 provides exemptions from the requirement to file an audited financial report for insurers or health maintenance organizations that have less than $1 million in direct premiums written in this state during a calendar year and that meet certain specified conditions. Section 401.007 provides exemptions from the requirement to file an audited financial report under the Insurance Code Chapter 401, Subchapter A, for an alien or foreign insurer or health maintenance organization that files an audited financial report in another state in accordance with that state's requirements for audited financial reports if the Commissioner finds that the other state's requirements are substantially similar to the requirements prescribed by Chapter 401, Subchapter A. Section 401.008 allows an insurer or health maintenance organization that is not eligible for an exemption under the Insurance Code §401.006 or §401.007 to apply to the

Commissioner for a hardship exemption and authorizes the Commissioner to grant the application under certain specified conditions. Section 401.009(a) - (c) specifies the contents of an audited financial report required under the Insurance Code §401.004, which must include (i) a description of the financial condition of the insurer or health maintenance organization as of the end of the most recent calendar year and the results of the insurer's or health maintenance organization's operations, changes in financial position, and changes in capital and surplus for that year; (ii) the report of an accountant; (iii) a balance sheet that reports admitted assets, liabilities, capital, and surplus; (iv) a statement of gain or loss from operations; (v) a statement of cash flows; (vi) a statement of changes in capital and surplus; (vii) any notes to financial statements; (viii) supplementary data and information, including any additional data or information required by the Commissioner; and (ix) information required by the Department to conduct the insurer's or health maintenance organization's examination under the Insurance Code Chapter 401, Subchapter B. Section 401.009(b) specifies the contents of the notes to financial statements required by §401.009(a)(3)(F), including (i) a reconciliation of any differences between the filed audited statutory financial statements and the annual statements with a written description of the nature of those differences; (ii) any notes required by the appropriate National Association of Insurance Commissioners annual statement instructions or by generally accepted accounting principles; and (iii) a summary of the ownership of the insurer or health maintenance organization and that entity's relationship to any affiliated company. Section 401.009(d) requires the

Commissioner to adopt rules governing the information required to be included in the audited financial report under the Insurance Code §401.009(a)(3)(H). Section 401.010(a) requires an accountant to audit the financial reports provided by an insurer or health maintenance organization for purposes of an audit under the Insurance Code Chapter 401, Subchapter A. Section 401.010(a) further requires the accountant who audits the reports to conduct the audit in accordance with generally accepted auditing standards or with standards adopted by the Public Company Accounting Oversight Board, as applicable, and the accountant must consider the standards specified in the Financial Condition Examiner's Handbook adopted by the National Association of Insurance Commissioners or other analogous nationally recognized standards adopted by Commissioner rule. Section 401.010(b) requires the financial statements included in the audited financial report to be prepared in a form and using language and groupings substantially the same as those of the relevant sections of the insurer's or health maintenance organization's annual statement filed with the Commissioner. Section 401.010(b) further requires that beginning in the second year in which an insurer or health maintenance organization is required to file an audited financial report, the financial statements must also be comparative, presenting the amounts as of December 31 of the reported year and the amounts as of December 31 of the preceding year. Section 401.011(a) provides that except as provided by Subsections (c) and (d), the Commissioner shall accept an audited financial report from an independent certified public accountant or accounting firm that (1) is a member in good standing of the

American Institute of Certified Public Accountants and is in good standing with all states in which the accountant or firm is licensed to practice, as applicable; and (2) conforms to the American Institute of Certified Public Accountants Code of Professional Conduct and to the rules of professional conduct and other rules of the Texas State Board of Public Accountancy or a similar code. Section 401.011(d) provides that the Commissioner may not accept an audited financial report prepared wholly or partly by an individual or firm who the Commissioner finds (1) has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act (18 U.S.C. Section 1961 et seq.), or a state or federal criminal offense involving dishonest conduct; (2) has violated the insurance laws of this state with respect to a report filed under the Insurance Code Chapter 401, Subchapter A; (3) has demonstrated a pattern or practice of failing to detect or disclose material information in reports filed under this subchapter; or (4) has directly or indirectly entered into an agreement of indemnity or release of liability regarding an audit of an insurer. Section 401.012 provides that the Commissioner may hold a hearing to determine if an accountant is qualified and independent. Section 401.012 further provides that if, after considering the evidence presented, the Commissioner determines that an accountant is not qualified and independent for purposes of expressing an opinion on the financial statements in an audited financial report filed under this subchapter, the Commissioner shall issue an order directing the insurer or health maintenance organization to replace the accountant with a qualified and independent accountant. Section 401.013 mandates that the audited financial

report required under the Insurance Code §401.004 must be accompanied by a letter provided by the accountant who performed the audit stating (1) the accountant's general background and experience; (2) the experience of each individual assigned to prepare the audit in auditing insurers or health maintenance organizations and whether the individual is an independent certified public accountant; and (3) that the accountant (A) is properly licensed by an appropriate state licensing authority, is a member in good standing of the American Institute of Certified Public Accountants, and is otherwise qualified under the Insurance Code §401.011; (B) is independent from the insurer or health maintenance organization and conforms to the standards of the profession contained in the American Institute of Certified Public Accountants Code of Professional Conduct, the statements of that institute, and the rules of professional conduct adopted by the Texas State Board of Public Accountancy, or a similar code; (C) understands that (i) the audited financial report and the accountant's opinion on the report will be filed in compliance with the Insurance Code Chapter 401, Subchapter A; and (ii) the Commissioner will rely on the report and opinion in monitoring and regulating the insurer's or health maintenance organization's financial position; and (D) consents to the requirements of the Insurance Code §401.020 and agrees to make the accountant's work papers available for review by the Department or the Department's designee. Section 401.014(a) requires an insurer or health maintenance organization to register in writing with the Commissioner the name and address of the accountant retained to prepare the audited financial report for

the insurer or health maintenance organization. Section 401.014(d) provides that the Commissioner may not accept the registration of a person who does not qualify under the Insurance Code §401.011 or does not comply with the other requirements of the Insurance Code Chapter 401, Subchapter A. Section 401.016 provides that an insurer or health maintenance organization described by §401.001(3) or (4) that is required to file an audited financial report may apply in writing to the Commissioner for approval to file audited combined or consolidated financial statements instead of separate audited financial reports if the insurer or health maintenance organization meets certain statutorily specified conditions. Section 401.017(a) requires an insurer or health maintenance organization required to file an audited financial report under the Insurance Code Chapter 401, Subchapter A, to require the insurer's or health maintenance organization's accountant to immediately notify the board of directors of the insurer or health maintenance organization or the insurer's or health maintenance organization's audit committee in writing of any determination by that accountant that the insurer or health maintenance organization has materially misstated the insurer's or health maintenance organization's financial condition as reported to the Commissioner as of the balance sheet date being audited; or the insurer or health maintenance organization does not meet the minimum capital and surplus requirements prescribed by the Insurance Code for the insurer or health maintenance organization as of that date. Section 401.018 provides that if, after the date of an audited financial report filed under the Insurance Code Chapter 401, Subchapter A, the accountant becomes aware of facts that might have

affected the report, the accountant must take action as prescribed in Volume 1, AU Section 561, Professional Standards of the American Institute of Certified Public Accountants. Section 401.019 provides that in addition to the audited financial report required by the Insurance Code Chapter 401, Subchapter A, each insurer or health maintenance organization shall provide to the Commissioner a written report of significant deficiencies required and prepared by an accountant in accordance with the Professional Standards of the American Institute of Certified Public Accountants; and shall annually file with the Commissioner the report required by this section not later than the 60th day after the date the audited financial report is filed. Section 401.019 further provides that the insurer or health maintenance organization shall provide a description of remedial actions taken or proposed to be taken to correct significant deficiencies, if the actions are not described in the accountant's report. Section 401.019 further requires that the report must follow generally the form for communication of internal control structure matters noted in an audit described in Statement on Auditing Standard (SAS) No. 60, AU Section 325, Professional Standards of the American Institute of Certified Public Accountants. Proposed new §7.88(j) is consistent with the new Statement on Auditing Standard No. 112. Section 401.020(b) requires an insurer or health maintenance organization required to file an audited financial report under the Insurance Code Chapter 401, Subchapter A, to require the insurer's or health maintenance organization's accountant to make available for review by the Department's examiners the work papers and any record of communications between the accountant and the insurer or health

maintenance organization relating to the accountant's audit that were prepared in conducting the audit. Section 401.020(b) further mandates the time periods for the retention of the accountant's work papers and records of communication. Section 401.020(c) authorizes the Department to copy and retain the copies of pertinent work papers when the Department's examiners conduct a review under 401.020(b). Section 401.020(c) also provides that the review is considered an investigation, and work papers obtained during that investigation may be made confidential by the Commissioner, unless the work papers are admitted as evidence in a hearing before a governmental agency or in a court. Section 401.021 provides that if an insurer or health maintenance organization fails to comply with the Insurance Code Chapter 401, Subchapter A, the Commissioner shall order that the insurer's or health maintenance organization's annual audit be performed by a qualified independent certified public accountant and authorizes the Commissioner to assess against the insurer or health maintenance organization the cost of auditing the insurer's or health maintenance organization's financial statement. Sections 401.051 and 401.056 mandate that the Department examine the financial condition of each insurer or HMO organized under the laws of Texas or authorized to transact the business of insurance in Texas. Section 401.056 requires the Commissioner to adopt rules relating to procedures governing the filing and adoption of an examination report and hearings to be held under the Insurance Code, Chapter 401, Subchapter B (Examination of Insurers or HMOs). Chapters 404 and 441 address the duties of the Department when an insurer's solvency is impaired. Chapter 404 authorizes

the Commissioner to set standards for evaluating the financial condition of an insurer. Section 404.003(a) authorizes the Commissioner to order an insurer, after notice and hearing, to take action reasonably necessary to remedy the condition if the financial condition of an insurer, when reviewed as provided by §404.003(b), indicates a condition that might make the insurer's continued operation hazardous to the insurer's policyholders or creditors or to the public. Section 404.005(a) authorizes the Commissioner to establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and standards for evaluating the financial condition of an insurer. Section 404.005(b) requires the standards established by the Commissioner under §404.005(a) to be consistent with the purposes of §404.003. Section 404.053(a) provides that if the Commissioner determines any of the circumstances described in §404.053(a)(1)(A) or (B) or (a)(2)(A) or (B), the Commissioner shall order an insurer to remedy an impairment of the insurer's surplus, aggregate surplus, or aggregate of guaranty fund and surplus, as applicable, by bringing the surplus to an acceptable level specified by the Commissioner. Section 404.053(b) requires that after issuing an order described in §404.053(a), the Commissioner to immediately institute any proceeding necessary to determine what further actions the Commissioner will take in relation to the matter. Section 421.001(c) requires the Commissioner to adopt each current formula recommended by the National Association of Insurance Commissioners for establishing reserves applicable to each line of insurance. Chapter 441 addresses the prevention of insurer

delinquencies. Section 441.001(e) sets forth the purpose of Chapter 441: (i) provide for the rehabilitation and conservation of insurers by authorizing and requiring supervision and conservatorship by the commissioner; (ii) authorize action to determine whether an attempt should be made to rehabilitate and conserve an insurer; (iii) avoid, if possible and feasible, the necessity of placing an insurer under temporary or permanent receivership; (iv) provide for the protection of an insurer's assets pending determination of whether the insurer may be successfully rehabilitated; and (v) alleviate concerns regarding insurance and insurers. Section 441.005 authorizes the Commissioner to adopt reasonable rules as necessary to implement and supplement Chapter 441 of the Insurance Code (Supervision and Conservatorship). Section 441.051 specifies “the circumstances in which an insurer is considered insolvent, delinquent, or threatened with delinquency” and includes certain statutorily specified conditions, including if an insurer’s required surplus, capital, or capital stock is impaired to an extent prohibited by law. Section 441.052 specifies “the circumstances in which an insurer is considered to have exceeded the insurer’s powers, including circumstances in which the insurer is in a condition that makes the insurer’s continuation in business hazardous to the public or to the insurer’s policyholders or certificate holders. Section 441.053 provides that if at any time the Commissioner determines that an insurer is insolvent, has exceeded the insurer’s powers, or has otherwise failed to comply with the law, the Commisioner shall: (1) notify the insurer of that determination; provide to the insurer a written list of the Commissioner’s requirements to abate the conditions

on which that determination was based; and if the Commissioner determines that the insurer requires supervision, notify the insurer that the insurer is under Commissioner's supervision and that the Commissioner is invoking this chapter. Section 441.102 requires an insurer under supervision to comply with the Commissioner's requirements under §441.053 not later than the 180th day after the date of the Commissioner's notice of supervision. Section 541.051(3) provides that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to make a misleading representation or misrepresentation regarding the financial condition of an insurer; or the legal reserve system on which a life insurer operates. Section 541.055(a) provides that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to, with intent to deceive, file with a supervisory or other public official a false statement of financial condition of an insurer; or make, publish, disseminate, circulate, deliver to any person, or place before the public or directly or indirectly cause to be made, published, disseminated, circulated, delivered to any person, or placed before the public a false statement of financial condition of an insurer. Section 541.055(b) provides that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to make a false entry in an insurer's book, report, or statement or willfully omit to make a true entry of a material fact relating to the insurer's business in the insurer's book, report, or statement with intent to deceive an agent or examiner lawfully appointed to examine the insurer's condition or affairs; or a public official to whom the insurer is required by law to report or who has authority by law to

examine the insurer's condition or affairs. Section 541.401 authorizes the Commissioner to adopt reasonable rules necessary to accomplish the purposes of trade practices regulation in Chapter 541. Section 801.101 authorizes the Commissioner to inquire into the competence, fitness, or reputation of (1) an officer or director of an insurer; or (2) a person having control of an insurer. Section 801.102 provides that if after conducting an inquiry under §801.101 the Department determines that, based on substantial evidence, the person who is the subject of the inquiry is not worthy of public confidence, the Department shall, after written notice and hearing, (1) deny the application for a certificate of authority; or (2) revoke the insurer's certificate of authority. Sections 802.001 authorizes the Commissioner, as necessary, to obtain an accurate indication of the company's condition and method of transacting business, to change the form of any annual statement required to be filed by any kind of insurance company, and to require certain insurers to make filings with the National Association of Insurance Commissioners. Section 802.002 provides that an insurance company's must include a statement of a qualified actuary titled "Statement of Actuarial Opinion" that (1) is located on or attached on the first page of the annual statement; and (2) provides the opinion of the actuary relating to policy reserves and other actuarial items for life insurance, accident and health insurance, and annuities, or loss and loss adjustment expense reserves for property and casualty risks as described in the annual statement instructions of the National Association of Insurance Commissioners as appropriate for the types of risks insured. Section 802.052(a) requires each domestic, foreign, or

alien insurance company authorized to engage in the business of insurance in this state to file a copy of the company's annual statement with the National Association of Insurance Commissioners at the time the company files the statement with the Commissioner. Section 802.052(b) requires the statement required by subsection (a) to (1) meet the requirements adopted by the Commissioner, including: (A) a change in substance or form; (B) an additional filing; and (C) any requirement that the statement be in a computer compatible format; and (2) include the signed jurat page and the actuarial opinion, as required by the jurisdiction in which the insurance company is domiciled. Section 802.053 provides that the Commissioner may exempt any class of insurance companies from the requirements of Chapter 802, Subchapter B if the Commissioner believes the information required under Subchapter B will not be useful for regulatory purposes. Section 802.054 provides that the Commissioner may consider a foreign insurance company to be in compliance with the requirements of §802.052 if the company is domiciled in a state with a law substantially similar to that section. Sections 822.210, 841.205, 843.404, and 884.206 authorize the Commissioner to adopt rules to require an insurer to maintain capital and surplus levels in excess of statutory minimum levels or an HMO to maintain a specified net worth to assure financial solvency of insurers or HMOs for the protection of policyholders and insurers or enrollees and HMOs, as applicable. Section 822.211 provides that if an insurance company does not comply with the capital and surplus requirements of Chapter 822, the Commissioner may enter an order prohibiting the company from writing new

business and placing the company under state supervision or conservatorship, declare the company to be in a hazardous condition as provided by Subchapter A, Chapter 404, declare the company to be impaired as provided by Subchapter B, Chapter 404, or apply to the company any other applicable sanction as provided by the Insurance Code. Section 841.207 provides that if an insurance company does not comply with the capital and surplus requirements of Chapter 841, the Commissioner may enter an order prohibiting the company from writing new business and placing the company under state supervision or conservatorship, declare the company to be in a hazardous condition as provided by Subchapter A, Chapter 404, declare the company to be impaired as provided by Subchapter B, Chapter 404, or apply to the company any other applicable sanction as provided by the Insurance Code. Section 841.206 provides that if the Commissioner determines that an insurance company's capital or surplus is impaired in violation of 841.206, the Commissioner shall order the insurer to immediately reduce the level of impairment to an acceptable level of impairment as specified by the Commissioner or prohibit the company from engaging in the business of insurance in this state; and begin proceedings as necessary to determine any further actions with respect to the impairment. Section 823.157 requires the Commissioner to consider, in considering whether to approve or deny an acquisition for change of control for which a statement is filed under §823.154, whether (1) immediately on the acquisition or change of control the domestic insurer would not be able to satisfy the requirements for the issuance of a new certificate of authority to write the line or lines of insurance for which the

insurer holds a certificate of authority; (2) the effect of the acquisition or change of control would be to substantially lessen competition in any line or subclassification lines of insurance in this state or tend to create a monopoly in a line or subclassification lines of insurance in this state; (3) the financial condition of the acquiring person may jeopardize the financial stability of the domestic insurer or prejudice the interest of its policyholders; (4) the acquiring person has any plan or proposal to liquidate the domestic insurer or cause the insurer to declare dividends or make other distributions, sell any of its assets, consolidate or merge with any person, make a material change in its business or corporate structure or management, or enter into any material agreement, arrangement, or transaction of any kind with any person, and that the plan or proposal is unfair, prejudicial, hazardous, or unreasonable to the domestic insurer's policyholders and not in the public interest; (5) due to a lack of competence, trustworthiness, experience and integrity of the persons who would control the operations of the domestic insurer, the acquisition or change of control would not be in the interest of the insurer's policyholders and of the public; or (6) the acquisition or change of control would violate the law of this state or another state or the United States. Section 843.151 authorizes the Commissioner to adopt reasonable rules as necessary to carry out the provisions of Chapter 843 of the Insurance Code (Health Maintenance Organizations), and §1367.053, Subchapter A, Chapter 1452; Subchapter B, Chapter 1507, Chapters 222, 251, and 258, as applicable to a health maintenance organization, and Chapters 1271 and 1272. Section 843.155 requires HMOs to file annual reports with the Commissioner, which

include a financial statement of the HMO, verified by at least two principal officers and certified by an independent public accountant. Section 843.157 provides that the rehabilitation, liquidation, supervision, or conservation of a health maintenance organization shall be treated as a rehabilitation, liquidation, supervision, or conservation of an insurer and be conducted under the supervision of the Commissioner under Chapter 441 or 443, as appropriate. Section 843.406 authorizes the Commissioner to establish, in a manner consistent with the purposes of this section, uniform standards and criteria for early warning that the continued operation of a health maintenance organization could be hazardous to the health maintenance organization's enrollees or creditors or the public; and standards for evaluating the financial condition of a health maintenance organization. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Department under the Insurance Code and other laws of this state.

8. CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal: Insurance Code Chapters 401, 404, 421, 441, 541, 801, 802, 822, 823, 841, 843, and 884.

9. TEXT.

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

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

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

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

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

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

(b) Applicability.

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

(2) Subsection (h)(1) of this section, relating to lead audit partner limitation, shall be in effect for audits of the year beginning January 1, 2010, which audits are reflected in reports and communications required to be filed with

the commissioner during calendar year 2011, and continues in effect each year thereafter.

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

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

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

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

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

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

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

823, or a set of insurers or HMOs as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting.

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

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

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

(B) a fire and marine insurance company;

(C) a general casualty company;

(D) a title insurance company;

(E) a fraternal benefit society;

(F) a mutual life insurance company;

(G) a local mutual aid association;

(H) a statewide mutual assessment company;

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

(J) a farm mutual insurance company;

(K) a county mutual insurance company;

(L) a Lloyd's plan;

(M) a reciprocal or interinsurance exchange;

(N) a group hospital service corporation;

(O) a stipulated premium company; and

(P) a nonprofit legal services corporation.

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

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

(B) provide reasonable assurance that:

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

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

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

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

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

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

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

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

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

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

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

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

(d) Filing and Extensions for Filing of Audited Financial Report.

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

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

business of insurance in another state that requires that an audited financial report be filed on or before June 1 for the preceding calendar year.

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

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

(5) An insurer or HMO required to file an annual audited financial report under the Insurance Code Chapter 401, Subchapter A, and this section shall designate a group of individuals to serve as its audit committee. The audit committee of an entity that controls an insurer or HMO may, at the election of the controlling person, be the insurer's or HMO's audit committee for purposes of this section.

(e) Exemption for Certain Foreign or Alien Insurers or HMOs.

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

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

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

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

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

(f) Requirements for Financial Statements in Audited Financial Report. The financial statements included in the audited financial report must be prepared in a form and use language and groupings substantially the same as the relevant sections of the annual statement of the insurer or HMO filed with the commissioner. The financial statements must be comparative, including amounts on December 31 of the current year and amounts as of the immediately

preceding December 31, except for the first year in which an insurer or HMO is required to file the report.

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

(h) Qualifications and Independence of Accountant; Acceptance of Audited Financial Report. Except as provided by the Insurance Code §401.011(b) and (d), and paragraphs (1), (3), (4), (5), and (10) of this subsection, the commissioner shall accept an audited financial report from an independent certified public accountant or accounting firm that is a member in good standing of the American Institute of Certified Public Accountants; is in good standing with

all states in which the accountant or firm is licensed to practice, as applicable; and conforms to the American Institute of Certified Public Accountants Code of Professional Conduct and to the rules of professional conduct and other rules of the Texas State Board of Public Accountancy or a similar code.

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

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

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

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

(2) On filing its annual statement, an insurer or HMO for which the commissioner has approved an exemption under paragraph (1) of this subsection

shall file the approval with the states in which it is doing business or is authorized to do business and with the National Association of Insurance Commissioners. If a state other than this state accepts electronic filing with the National Association of Insurance Commissioners, the insurer or HMO shall file the approval in an electronic format acceptable to the National Association of Insurance Commissioners.

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

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

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

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

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

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

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

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

(E) internal audit outsourcing services;

(F) management or human resources services;

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

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

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

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

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

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

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

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

(7) An accountant who performs an audit may perform non-audit services, including tax services, that are not described in paragraph (4) of this subsection or that do not conflict with paragraph (3) of this subsection, only if the activity is approved in advance by the audit committee in accordance with paragraph (8) of this subsection.

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

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

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

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

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

(10) The commissioner may not recognize an accountant as qualified or independent for a particular insurer or HMO if a member of the board, the president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for the insurer or HMO, was employed by the accountant and participated in the audit of that insurer or HMO during the one-year period preceding the date on which the most current statutory opinion is due. This paragraph applies only to partners and senior managers involved in the audit. An insurer or HMO may apply to the commissioner for an exemption from the requirements of this paragraph on the basis of unusual circumstances.

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

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

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

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

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

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

(i) Accountant's Letter of Qualifications. The audited financial report required under the Insurance Code §401.004 must be accompanied by a letter, provided by the accountant who performed the audit, that includes the representations and statements required under the Insurance Code §401.013,

and a representation that the accountant is in compliance with the requirements specified in subsection (h) of this section.

(j) Communication of Internal Control Matters Noted in Audit.

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

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

(k) Requirements for Audit Committees.

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

(A) a foreign or alien insurer or HMO;

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

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

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

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

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

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

(C) except as provided in paragraph (3) of this subsection, an insurer with less than $300 million in direct and assumed premiums for the preceding calendar year is not required to comply with the independence requirements in this subsection for its audit committee.

(3) Notwithstanding subsection (k)(1) and (9) of this section, the commissioner may require the insurer's or HMO's board to enact improvements to the independence of the audit committee membership if the insurer or HMO:

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

(B) meets one or more of the standards of an insurer or HMO considered to be in hazardous financial condition as described by or provided in the Insurance Code Chapter 404, 441, or 843 or rules adopted thereunder, including Chapter 8 of this title (relating to Early Warning System for Insurers in Hazardous Condition) and §11.810 of this title; or

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

(4) An insurer or HMO with direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, of less than $500 million may apply to the commissioner for a waiver from the requirements of paragraphs (1), (2), and (5) – (12) of this subsection based on hardship. The insurer or HMO shall file, with its annual statement filing, the approval of a waiver under this paragraph with the states in which it does business or is authorized to do business and with the National Association of Insurance Commissioners. If a state other than this state accepts electronic filing, the insurer or HMO shall file the approval in an

electronic format acceptable to the National Association of Insurance Commissioners.

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

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

(7) Each member of the audit committee must be a member of the board of directors of the insurer or HMO or, at the election of the controlling person, a member of the board of directors of an entity that controls the group of insurers or HMOs as provided under paragraph (10) of this subsection and described under subsection (c)(3) of this section.

(8) To be independent for purposes of this subsection, a member of the audit committee may not, other than in the person's capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory, or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary of the entity. To the extent of any conflict with a statute requiring an otherwise non-independent board member

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

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

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

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

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

(11) The audit committee shall require the accountant who performs an audit required by the Insurance Code Chapter 401, Subchapter A, and this section to report to the audit committee in accordance with the requirements of Statement on Auditing Standards No. 114, "The Auditor's

Communication With Those Charged With Governance," or a successor document, including:

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

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

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

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

(12) If an insurer or HMO is a member of an insurance holding company system, the report required by paragraph (11) of this subsection may be provided to the audit committee on an aggregate basis for insurers or HMOs in the holding company system if any substantial differences among insurers or HMOs in the system are identified to the audit committee.

(l) Prohibited Conduct in Connection with Preparation of Required Reports and Documents.

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

(A) make or cause to be made a materially false or misleading statement to an accountant in connection with an audit, review, or

communication required by the Insurance Code Chapter 401, Subchapter A, or this section; or

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

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

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

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

(C) not to withdraw an issued report; or

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

(m) Report of Internal Control over Financial Reporting.

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

(2) Notwithstanding the premium threshold under paragraph (1) of this subsection, the commissioner may require an insurer or HMO to file the management's report of internal control over financial reporting if the insurer or HMO is in any risk-based capital level event or meets one or more of the standards of an insurer or HMO considered to be in hazardous financial condition as described by or provided in the Insurance Code Chapter 404, 441, 822, 841,

843, or 884 or rules adopted thereunder, including §7.402 of this title, Chapter 8 of this title, and §11.810 of this title.

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

(A) directly subject to Section 404;

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

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

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

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

preparation of the insurer's or HMO's or group of insurers' or HMOs' audited statutory financial statements and those internal controls are not included in the Section 404 report, the insurer or HMO or group of insurers or HMOs may either file:

(A) a report under this subsection; or

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

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

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

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

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

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

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

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

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

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

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

(8) Management has discretion as to the nature of the internal control framework used, and the nature and extent of the documentation required by paragraph (7) of this subsection, in order to form its opinions in a cost-

effective manner and may include an assembly of or reference to existing documentation.

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

(n) Transition Dates.

(1) An insurer or HMO or group of insurers or HMOs whose audit committee as of August 1, 2010, is not subject to the independence requirements of subsection (k) of this section because the total written and assumed premium is below the threshold specified in subsection (k)(2)(A) or (B) of this section and that later becomes subject to one of the independence requirements because of changes in the amount of written and assumed premium, has one year following the year in which the written and assumed premium exceeds the threshold amount to comply with the independence requirements. An insurer or HMO that becomes subject to one of the independence requirements as a result of a business combination must comply with the independence requirements not later than the first anniversary of the date of the acquisition or combination.

(2) An insurer or HMO or group of insurers or HMOs that is not required by subsection (m)(1) of this section to file a report beginning with the reporting period ending December 31, 2010, because the total written premium is below the threshold amount, and that later becomes subject to the reporting

requirements, has two years after the year in which the written premium exceeds the threshold amount to file a report. An insurer or HMO acquired in a business combination must comply with the reporting requirements not later than the second anniversary of the date of the acquisition or combination.

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

10. CERTIFICATION. This agency hereby certifies that legal counsel has reviewed the proposal and found it to be within the agency's authority to adopt.

Issued at Austin, Texas on ___________________________, 2010.

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