SUBCHAPTER C. Texas Medical Liability Insurance Underwriting Association

28 TAC §§5.2001–5.2006

INTRODUCTION. The Commissioner of Insurance adopts amendments to 28 TAC §§5.2001–5.2006, relating to the Texas Medical Liability Insurance Underwriting Association (JUA) Plan of Operation (Plan). Sections 5.2001, 5.2005, and 5.2006 are adopted without changes to the text as proposed in the July 24, 2020, issue of the *Texas Register* (45 TexReg 5116). The Texas Department of Insurance (TDI) made nonsubstantive changes to the proposed text in §§5.2002–5.2004.

REASONED JUSTIFICATION. The Texas Legislature formed the JUA in 1975 to be the residual market for medical liability insurance. The JUA is governed by a board of directors composed of nine members who are representatives from various industry groups and public members. Insurance Code §2203.052(a)(1) provides that five of the nine members of the board must be representatives of insurers, elected by association members.

Section 5.2002(d)(2)(B) fulfilled that requirement, in part, by providing that the Property Casualty Insurers Association of America (PCI) and the American Insurance Association (AIA) each select a member. PCI and AIA merged into the American Property Casualty Insurance Association (APCIA), effective January 1, 2019. To address the change, at their meeting on February 27, 2020, the JUA board voted to replace PCI and AIA with APCIA and the National Association of Mutual Insurance Companies (NAMIC). The amendments to §5.2002(d)(2)(B) will allow APCIA to appoint one member and NAMIC to appoint another so that the number of board members remains at nine.

Also, the amendments update several statutory references, make changes for agency style, and add the option for a foreign insurer to be a board member. A "foreign insurer" is an insurer that is licensed to do business in Texas but is domiciled in another state.

Section 5.2001. This section is amended to update statutory citations and make other nonsubstantive edits for current agency style, including removing "shall" in places where it is unnecessary.

Section 5.2002. Section 5.2002(d)(2)(B) is amended to allow APCIA to appoint one board member and NAMIC to appoint another so that the number of members remains at nine.

Section 5.2002(d)(2)(C)(ii) is amended to add an option for one board member slot to be filled either by an insurer who is not a member of the listed trade associations (which was provided for in the previous rule) or by a foreign insurer. This addition will add flexibility in choosing board members.

Section 5.2002 is also amended to update statutory citations and make other nonsubstantive edits to update the language to current agency style. This includes removing "shall" and replacing it with "will" or "must" where that word is clearer, capitalizing "Commissioner," and editing for plain language.

The text of §5.2002 is adopted with nonsubstantive changes to the proposed text to add clarity and consistency in the rule text and conform with the department's current writing style. In §5.2002(c)(3) the word "less" is changed to "fewer." In §5.2002(d)(8) the proposal changed "at the meeting which shall be adjourned" to "at the meeting which will be adjourned." In the adopted rule, the word "which" is changed to "that." In §5.2002(d)(11) the word "multi-year" is changed to "multiyear." A proposed amendment

to §5.2002(h)(5) would have changed "In each instance in which a question of indemnification arises" to "In each instance in when a question of indemnification arises." In the adopted rule, the word "when" is changed to "that." And, in §5.2002(i) the word "of" is changed to "to."

Section 5.2003. This section is amended to update statutory citations and make other nonsubstantive edits to update the language to current agency style, including replacing "shall" with "will" or "must" where that word is clearer, capitalizing "Commissioner," and editing for plain language.

The text of §5.2003 is adopted with nonsubstantive changes to the proposed text to add clarity and consistency in the rule text and conform with the department's current writing style. In §5.2003(b)(2)(A)(i) an unnecessary "or" is deleted and in §5.2003(e) the word "which" is changed to "that."

Section 5.2004. Section 5.2004 is amended to update the language to current agency style, including capitalizing "Commissioner" and revising punctuation. Section 5.2004(a)(2)(B) is amended to provide a more specific statutory citation.

The text of §5.2004 is adopted with nonsubstantive changes to the proposed text to add clarity and consistency in the rule text and conform with the department's current writing style. In §5.2004(a)(5)(E)(vii)(I) and (II), two unnecessary uses of "and" are deleted. In §5.2004(b)(4)(A)(v) the word "that" is changed to "who." In §5.2004(b)(4)(A)(vi) the word "then" is added after "licensing agency." In §5.2004(b)(4)(A)(viii) the word "and" is added after "applicant." And, in §5.2004(c)(1)(D) and (E) two unnecessary instances of "or" are deleted.

Section 5.2005. This section is amended to replace the word "shall" with "may" and capitalize "Commissioner" to conform with current agency style.

Section 5.2006. This section is amended to update statutory citations, remove "shall" and replace it with a clearer word, and capitalize "Commissioner" to conform with current agency style.

SUMMARY OF COMMENTS. TDI did not receive any comments on the proposed amendments.

STATUTORY AUTHORITY. The Commissioner adopts the amendments to 28 TAC §§5.2001–5.2006 under Insurance Code §§2203.053, 2203.054, and 36.001.

Insurance Code §2203.053(a) provides that the JUA operates under a plan of operation adopted by the Commissioner.

Insurance Code §2203.054 provides that amendments to the Plan must be approved by the Commissioner or made at the direction of the Commissioner.

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

TEXT.

§5.2001. Definitions.

(a) Words defined in the Insurance Code. Unless the context clearly dictates the contrary, words defined in Insurance Code Chapter 2203 and Insurance Code Article 21.49-3, §2, and not specifically defined in this section have the same definition when used in this subchapter as they have in the Insurance Code.

(b) Words defined in this subchapter. The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise:

(1) Act--The Texas Medical Liability Insurance Underwriting Association Act, codified as Insurance Code Chapter 2203 and Insurance Code Article 21.49-3, §§2,11, 12, and 13.

(2) Application--An application for medical liability insurance and general liability insurance issued in connection with medical liability insurance.

(3) Association--Texas Medical Liability Insurance Underwriting Association.

(4) Board of directors--The board of directors of the Texas Medical Liability Insurance Underwriting Association.

(5) Chairman of the board--The chairman of the board of directors of the Texas Medical Liability Insurance Underwriting Association.

(6) Charter member of the association--An insurer authorized to write and engaged in writing, in Texas on a direct basis, automobile liability and/or liability other than automobile insurance at any time between January 1, 1975, and the effective date of the Act.

(7) Commissioner--Commissioner of Insurance.

(8) Department--Texas Department of Insurance.

(9) Member--An insurer required to be a member of the association by Insurance Code §2203.055 or, where the context indicates, any duly authorized agent or representative of such insurer. "Members" means more than one member.

(10) Secretary--The secretary of the Texas Medical Liability Insurance Underwriting Association.

(11) Treasurer--The treasurer of the Texas Medical Liability Insurance Underwriting Association.

(12) Vice chair or vice chair of the board--The vice chair of the board of directors of the Texas Medical Liability Insurance Underwriting Association.

§5.2002. Operation of the Texas Medical Liability Insurance Underwriting Association.

(a) Membership. The association is governed by Insurance Code Chapter 2203. Any insurer authorized to write and engaged in writing any insurance, the writing of which requires the insurer to become a member of the association under Insurance Code §2203.055, will become a member of the association on the first day of January immediately following the date the insurer started writing such insurance. The determination of the insurer's participation in the association will be made as of the date of such membership in the same manner as for all members of the association. Any member that ceases to be authorized to write or that ceases to engage in the writing of any insurance that would require such insurer to become a member of the association will remain a member of the association until midnight of December 31 next following the date the insurer ceases to be authorized to write or ceases to write such insurance, and the insurer's participation in the association will cease as of that time; provided, however, that each member must participate in any financial deficit of the association for all calendar years subsequent to December 31, 1976, during which the insurer was a member of the association, whenever such deficit is determined. The member must be charged or credited in due course with its proper share of all expenses or losses and any recoupment or reimbursement allocable to the member. If a member is merged or consolidated with

another insurer, the continuing insurer will become a member of the association in place of the merged or consolidated member, provided that such member will be deemed to have become a member of the association on the date the merged or consolidated member became a member and provided, further, that such member will pay no initial expense fee.

(b) Expense fees.

(1) Initial expense fee. Each member must pay to the association an initial expense fee of $100. All members of the association must pay such fees on or before the date they become members of the association.

(2) Annual expense fee. In addition to the initial expense fee, each member must pay to the association an annual expense fee in an amount to be determined by the board of directors and approved by the Commissioner. All members of the association must pay such annual expense fee on or before the first of January for each year during which the association exists.

(3) Remedy for failure to pay fees. If any member fails or refuses to pay either the initial expense fee or the annual expense fee after receipt of written notice by the association that such fee is due and payable, then such member will be subject to the same remedies as provided in §5.2003(d)(4) of this title (relating to Property and Casualty Insurance) for the failure of the member to pay any assessment levied by the association.

(4) Use of fees. All expense fees paid to the association will be used in such manner as the board of directors may from time to time direct in accordance with this subchapter.

(c) Meetings of members.

(1) Notice of meetings. Written or printed notice stating the place, date, hour, subjects of the meeting, and the purpose or purposes for which the meeting is called, must be delivered not less than 10 nor more than 50 days before the date of the meeting, either personally or by mail, by or at the direction of the chair of the board of directors, the secretary, or other person calling the meeting, to each member entitled to vote at such meeting. Public notice of meetings must be given as required by Government Code Chapter 551.

(2) Meetings.

(A) Annual meeting. The annual meeting of the members must be held not later than the 30th day of September of each year at an hour and place to be determined by the board of directors for the purpose of electing directors and for the transaction of such other business as may come before the meeting. If the election of directors is not held on the day designated for any annual meeting of the members, the board of directors must cause the election to be held at a special meeting of the members as soon as may be convenient after the annual meeting.

(B) Special meetings. The board of directors, the chair of the board of directors, or 20% of the members may call a special meeting of the members and designate any place as the place of the special meeting.

(3) Quorum. Fifty members, represented by person or by proxy, is a quorum at a meeting of the members. If fewer than 50 members are represented at a meeting, a majority of the members represented may adjourn the meeting from time to time without further notice. At the next meeting after adjournment at which a quorum is present or represented, any business may be transacted at the meeting as originally notified. The members represented at a duly organized meeting may continue to transact business

until adjournment, notwithstanding the withdrawal of enough persons to leave less than a quorum.

(4) Voting.

(A) Each member is entitled to one vote at the annual meeting and each special meeting.

(B) A member may vote by proxy executed in writing by the member. No proxy will be valid after the next annual meeting after the date of its execution unless otherwise provided in the proxy. Each proxy is revocable.

(C) Each member's vote may be voted by such officer, agent, or proxy as the bylaws of such member may authorize or, in the absence of such authorization, as such member may determine.

(D) Voting on any question or in any election may be by voice vote or by show of hands unless the presiding officer orders, or any member demands, that voting be by written ballot.

(5) Rules. To the extent applicable, Robert's Rules of Order govern the conduct of and procedure at all meetings of the members.

(d) Directors.

(1) Selection. At each annual meeting of members or as otherwise provided in subsection (c)(2) of this section, the members must elect five directors from member companies for the categories set forth in paragraph (2)(B) and (C) of this subsection. Four directors must be selected in the manner set forth in paragraph (2)(D)–(F) of this subsection. Directors take office on October 1 of each year and will hold office until the next election of directors or until a successor has been selected and qualified.

(2) Membership.

(A) The number of the directors of the association must be nine.

(B) Three directors to be elected in accordance with paragraph (1) of this subsection must be elected by the members and be separate members of the association representing each of the following:

(i) the American Property Casualty Insurers Association;

(ii) the National Association of Mutual Insurance Companies; and

(iii) the Insurance Council of Texas.

(C) Two directors must be elected by the members and must be:

(i) a member insurer organized under the laws of and domiciled in Texas; and

(ii) a member insurer that is either (or both):

(I) not a member of those associations described in subparagraph (B) of this paragraph, or

(II) an insurer that is not domiciled in Texas.

(D) One director must be a physician who is appointed by the Texas Medical Association or its successor.

(E) One director must be a representative of hospitals appointed by the Texas Hospital Association or its successor.

(F) Two directors must be members of the public to be appointed by the Commissioner.

(G) No director may fill more than one seat on the board of directors, and no member affiliated by ownership, management, or control may simultaneously occupy seats on the board of directors. No later than 60 days before the annual meeting,

the board of directors must select a nominating committee of three member companies. The three directors who will represent the organizations set forth in subparagraph (B) of this paragraph must be nominated by the nominating committee. The two directors described in subparagraph (C) of this paragraph must be nominated by any member of the association by submitting the nominee's name to the nominating committee. To be eligible for selection to the board of directors by the members, a member must be nominated at least 30 days before the annual meeting at which such directors are selected.

(3) Term of office. Unless removed in accordance with this subchapter, each director will hold office until the next election of directors or until a successor has been selected and qualified.

(4) Regular meetings. A regular meeting of the board of directors must be held with notice as provided for in this subsection, immediately after and at the same place as the annual meeting of the members. The board of directors may provide, by resolution, the time and place for the holding of additional regular meetings with notice to the directors at least 10 days before each regular meeting as provided in this subsection.

(5) Notice of regular or special meeting. Notice of any regular or special meeting must be given at least 10 days before the meeting. The association must provide notice by personal delivery, mail, electronic, or other means to each director. If mailed, notice will be deemed to be delivered when deposited in the United States mail, addressed with postage prepaid. If the notice is by other reasonable means, the association must maintain a written record of the method of notification. Any director may waive notice of any meeting. The attendance of a director at a meeting is a waiver of

notice of the meeting, except where a director attends a meeting for the express purpose of objection to the transaction of any business because the meeting is not lawfully called or convened.

(6) Special meetings. Special meetings of the board of directors may be called by the chair of the board, or at the request of any two directors. The person or persons who call special meetings of the board of directors may fix any place that is accessible to the public as the place for holding any special meeting of the board of directors called by them.

(7) Statement of purpose of meeting required. The business to be transacted at, and the purpose of, any regular or special meeting of the board of directors must be specified in the notice, or waiver of notice, of the meeting, and in the notice required by Government Code Chapter 551.

(8) Quorum. A majority of directors is a quorum for the transaction of business at any meeting of the board of directors. Action taken by a majority of directors present at a meeting at which a quorum is present will be the act of the board of directors. If at any meeting of the board of directors there is less than a quorum present, a majority of those present may adjourn the meeting from time to time until a quorum is obtained, and no further notice need be given other than by announcement at the meeting that will be adjourned.

(9) Presumption of assent. A director of the association who is present at the meeting of the board of directors at which action on any matter is taken is presumed to have assented to the action taken unless the director's dissent is entered in the minutes of the meeting, or unless a written dissent to the action is filed with the person acting as

secretary of the meeting before the adjournment. The right to dissent is not available to a director who voted in favor of the action.

(10) Compensation. By resolution of the board of directors, the directors and members of committees of the association may be paid their expenses, if any, of attendance at each meeting of the board of directors or each meeting of a committee of the association. No other payment may be made to directors other than that provided in this paragraph except that nothing in this subchapter may be construed as preventing any director from receiving compensation for serving the association in any other capacity.

(11) General powers. The board of directors must manage the business and affairs of the association subject to the supervision and control, at all times, of the Commissioner and the department as set forth in this subchapter and in the Act. Included among the powers of the board of directors, but not in limitation thereof, are the following:

(A) to purchase or otherwise acquire for the association any property, rights, or privileges that the association is authorized to acquire;

(B) to remove any officer summarily for cause, or without cause and, in their discretion, from time to time to dissolve the powers and duties of any officers and to confer the powers and duties upon any other person;

(C) to appoint and remove or suspend such subordinate officers, agents, employees, or representatives as they may deem necessary and to determine their duties, and fix, and from time to time change, their salaries or remuneration, and to require security as and when they think fit;

(D) to confer upon any officer of the association the power to appoint, remove, and suspend subordinate officers or employees;

(E) to determine who may be authorized on the association's behalf to make and sign bills, notes, acceptances, endorsements, checks, releases, receipts, contracts, and other instruments;

(F) to delegate any of the powers of the board of directors in relation to the ordinary business of the association to any standing or special committee, or to any officers or agent (with power to subdelegate) upon such terms as they think fit;

(G) to contract, from time to time, with one or more members for single or multiyear terms, to act as servicing carriers to perform all policy functions of the association, including, without limitation to, underwriting, issuance of policy, coding and premium accounting, settlement of claims to conclusion, and reporting to the association, as may be directed by the association, subject to provisions of law and this subchapter, upon the terms and for the consideration expressed. Such contracts may not become effective until the contracts have been approved by the department;

(H) to approve expenses and levy assessments, including preliminary assessments for initial expenses necessary to commence operations, and assessments to defray losses and expenses;

(I) to establish necessary facilities;

(J) to enter into commission arrangements with agents regarding the sale of medical liability insurance through the association;

(K) to promulgate reasonable and objective underwriting standards;

(L) to either or both accept and refuse the assumption of reinsurance from its members and cede and purchase reinsurance, provided, however, that the reinsurance is governed by rules promulgated by the Commissioner; and

(M) to direct the collection, administration, investment, and valuation of the stabilization reserve funds consistent with the Act and this subchapter.

(12) Committees.

(A) The board of directors, by resolution or resolutions passed by a majority of the board of directors, may designate one or more committees, each committee to consist of two or more of the directors of the association that, to the extent provided in the resolution or resolutions, will have and may exercise the powers of the board of directors in the management of the business and affairs of the association. The committee or committees will have the name or names as may be determined from time to time by appropriate resolution. All committees must keep regular minutes of their proceedings and report the minutes to the board of directors when required.

(B) The chair may appoint the members of the committees as may be appropriate to carry out the business of the association.

(C) The delegation to a committee of authority consistent with this section may not operate to relieve the board of directors, or any director, of any responsibility imposed upon the board of directors or director by law.

(13) Removal. Any person serving as a director may be removed from a position as director either with or without cause at any special meeting of members if notice of intention to remove the director has been stated as one of the purposes of the meeting. This paragraph may not be construed to allow the removal of any member from the board of directors.

(14) Vacancies.

(A) A director position is considered vacant upon the resignation of the member serving as director.

(B) Any vacancy occurring in the board of directors may be filled at the next meeting of the board of directors following the occurrence of such vacancy. Subject to the provisions of paragraph (2) of this subsection, such vacancy must be filled by the affirmative vote of a majority of the remaining directors though less than a quorum. A director elected to fill a vacancy must be elected for the unexpired term of its predecessor.

(15) Executive committee. The board of directors, by resolution or resolutions passed by a majority of the board of directors, may designate an executive committee to consist of a chair, a vice chair, a secretary, a treasurer, and the immediate past chair, provided the immediate past chair is a director. The general manager must be an ex officio member of the executive committee. To the extent provided in the resolution or resolutions, the executive committee has and may exercise the powers of the board of directors in the management of the business and affairs of the association. The executive committee must keep regular minutes of its proceedings and report the minutes to the board of directors. The delegation authority consistent with this section does not operate to relieve the board of directors, or any director, of any responsibility imposed by law upon the board of directors or any director.

(e) Officers.

(1) Number. The officers of the association are the chair of the board of directors, the vice chair of the board of directors, the secretary, the treasurer, and other officers as the Commissioner may desire, all of whom are elected by the board of directors.

No two offices may be held by the same person except for the offices of secretary and treasurer.

(2) Election and term of office. The officers of the association are elected annually by the board of directors at the first meeting of the board of directors held after each annual meeting of the members or as soon as practical following the annual meeting. Each officer must hold office until a successor has been duly elected and qualified or until the officer's resignation, death, or removal.

(3) Removal and vacancies. Any officer or agent elected or appointed by the board of directors may be removed by the board of directors whenever, in its judgment, the best interests of the association would be served or otherwise in accordance with this subchapter, but such removal is without prejudice to the contract rights, if any, of the person so removed. A vacancy in any office because of death, resignation, removal, disqualification, or otherwise may be filled by the board of directors for the unexpired portion of the term.

(4) Chair of the board. The chair of the board must preside at all meetings of the members and at all meetings of the directors, appoint and discharge employees and agents of the association subject to the approval of the directors, fix the compensation of employees and agents, make and sign contracts and agreements in the name of the association, and appoint committees. The chair of the board must ensure that the books, reports, statements, and certificates are properly kept, made, and filed, if necessary, and the chair of the board must generally do and perform all acts incident to the office of chair of the board or that may be authorized or required by law, by this subchapter, or by the board of directors, not inconsistent with this subchapter.

(5) Vice chair of the board. The vice chair, elected by the board of directors, has powers and must perform duties as assigned to the vice chair, not inconsistent with this subchapter.

(6) Secretary. The secretary must:

(A) keep the minutes of the members and of the board of directors' meetings in one or more books provided for that purpose;

(B) provide all notices as required by the provisions of this subchapter. In case of the secretary's absence or refusal or neglect to give the required notice, notice may be given at the direction of the chair of the board of directors, or of the members upon whose request the meeting is called;

(C) be custodian of the association's records;

(D) keep a register of the post office address of each member;

(E) annually determine each member's participation in the association in the manner required by the Act and this subchapter and keep a register of each member's percentage of participation; and

(F) in general, perform all duties incident to the office of secretary and such other duties as from time to time may be delegated to the secretary by the chair of the board or by the board of directors.

(7) Treasurer. The treasurer must have custody of all funds, securities, evidences of indebtedness, and other valuable documents of the association, including those attributable to the stabilization reserve funds. The treasurer must receive and give, or cause to be given, receipts and acquittances for money paid in on account of the association, and pay out of the funds on hand all just debts of the association, of whatever nature, upon maturity of the debts. The treasurer must enter, or cause to be entered, in

books of the association to be kept for that purpose, full and accurate accounts of all money received and paid out on account of the association, and whenever required by the board of directors, the treasurer must keep, or cause to be kept, other books as would show a true record of the reserves, expenses, losses, gains, assets, and liabilities of the association.

(f) Fiscal year. The fiscal year of the association is the calendar year.

(g) Waiver of notice. Whenever any notice is required to be given to any members or director of the association under the provisions of this subchapter, a waiver in writing signed by the person or persons entitled to notice is deemed equivalent to the giving of such notice.

(h) Protection of directors and officers.

(1) Any person or insurer made or threatened to be made a party to any civil, criminal, administrative, or investigative action, suit, or proceeding (other than an action by or in the right of the association) because such person or insurer is or was a member or is serving or served on a committee or is or was an officer or employee of the association or is or was serving any other entity or organization at the request of the association is entitled to be indemnified by the association against all judgments, fines, amounts paid in settlement, reasonable costs and expenses (including attorneys' fees), and other liabilities actually and reasonably incurred (other than for amounts paid to the association itself) as a result of such threatened or actual action, suit, or proceeding except in relation to matters as to which that person or insurer is finally adjudged in such action, suit, or proceeding to be liable by reason of willful misconduct in the performance of that person's or insurer's duties or obligations to the association or other entity as previously provided and, with respect to any criminal actions or proceedings, except when such

person or insurer believed or had reasonable cause to believe that their conduct was unlawful.

(2) Indemnification must be provided whether or not such person or insurer is a member or is holding office or is employed or serving at the time of such action, suit, or proceeding, and whether or not any such liability was incurred prior to the adoption of this subchapter.

(3) Indemnification is not exclusive of other rights such person or insurer may have, and passes to the successors, heirs, executors, or administrators of such person or insurer.

(4) The termination of any such action, suit, or proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent will not in itself create a presumption that such person or insurer was liable by reason of willful misconduct or that they had reasonable cause to believe that their conduct was unlawful.

(5) In each instance that a question of indemnification arises, entitlements thereto, pursuant to the condition set forth in this subsection, must be determined by the board of directors by a majority vote of a quorum consisting of directors that were not parties to such action, suit, or proceeding or by the board of directors, whether interested or disinterested, if based upon a written opinion of legal counsel that the action, suit, or proceeding could qualify for indemnification because of reasonable doubt that the directors were liable by reason of willful misconduct in the performance of duties or obligations to the association or other entity as provided in this subsection, or that there was reasonable doubt that the directors believed or had reasonable cause to believe that the conduct was unlawful, and the board of directors must also determine the time and manner of payment of such indemnification; provided, however, if any such action, suit,

or proceeding is terminated by compromise settlement, indemnification in respect of such disposition must be made only if such settlement had the prior approval of the board of directors, and provided further that a person or insurer who or that has been wholly successful, on the merit or otherwise, in the defense of a civil or criminal action, suit, or proceeding of the character described in this subsection will be entitled in every instance to indemnification as authorized in this subchapter.

(6) Expense incurred in defending a civil or criminal action, suit, or proceeding may be paid by the association in advance of the final disposition of the action, suit, or proceeding, as authorized by the board of directors in the specific case, upon receipt of an undertaking by or on behalf of the person or insurer to repay the amount, unless it is determined that the person or insurer is not entitled to be indemnified by the association.

(7) Nothing in this subsection is deemed to preclude a person or insurer who or that the board of directors has determined not to be entitled to indemnification from asserting the right to such indemnification by legal proceedings.

(8) Indemnification as provided in this subsection is apportioned among all members, including any named in any such action, suit, or proceeding, in the same manner as other operating expenses of the association.

(i) Annual report. The treasurer must file with the department annually, on or before the first day of March, a statement that contains information on the association's transactions, condition, operations, and affairs during the preceding calendar year. Such statement must be in the form and contain the matters and information prescribed by the department. The department may, at any time, require the association to furnish additional information with respect to its transactions, condition, or any matter

considered to be material and of assistance in evaluating the scope, operation, and experience of the association.

(j) Examinations. The department must examine the affairs of the association in accordance with Insurance Code Chapter 401.

§5.2003. Members' and Policyholders' Participation in the Texas Medical Liability Insurance Underwriting Association.

(a) Powers of the association. The association is created by the Act and will be governed by the provisions of the Act and this subchapter.

(b) Collection and investment of funds.

(1) Collection. The treasurer is responsible for the collection of all the premiums received by the association, all assessments levied against the members, all assessments and charges levied against policyholders (including contributions to the stabilization reserve funds), and all proceeds from the investment of funds.

(2) Investment.

(A) All funds collected by the association must be retained in appropriate accounts in any bank or banks doing business in Texas and may be invested only in the following:

(i) interest-bearing time deposits or certificates of deposit in any bank or banks doing business in Texas that are members of the Federal Deposit Insurance Corporation;

(ii) treasury bills, notes, or bonds of the government of the United States of America; or

(iii) other investments as may be proposed by the board of directors and approved by the Commissioner.

(B) The board of directors must determine what portion of such funds should be retained in a checking account or accounts and what portion of such funds should be invested in the investments set forth in subparagraph (A) of this paragraph, as well as which specific investments, if any, should be made.

(c) Stabilization reserve funds. Insurance Code §2203.301 creates a policyholder's stabilization reserve fund for physicians and certain health care providers (§2203.301 fund), and Insurance Code §2203.303 creates a stabilization reserve fund for for-profit and not-for-profit nursing homes and assisted living facilities (§2203.303 fund) and further provides that these funds must be administered as provided in Insurance Code Chapter 2203 and this subchapter and that the advisory directors must be chosen as provided in this subchapter.

(1) General provisions.

(A) In accordance with Insurance Code §2203.101 and §2203.103, the Commissioner will establish by order the categories of physicians and other health care providers, including health care practitioners, and health care facilities, who are eligible to obtain coverage from the association. The order may indicate the stabilization reserve fund appropriate to the new category and may be revised from time to time to include or exclude from eligibility some categories of health care providers and physicians.

(B) The following provisions also govern the stabilization reserve funds under Insurance Code §2203.301 and §2203.303:

(i) Within 15 days after the effective date of any Commissioner order establishing eligibility, the board of directors must extend invitations to the

appropriate Texas organizations representing eligible §2203.301 fund health care providers and physicians and §2203.303 fund for-profit and not-for-profit nursing homes and assisted living facilities to each designate an advisory director to represent each eligible category of §2203.301 fund health care provider and physician and §2203.303 fund for-profit and not-for-profit nursing home and assisted living facility, and advise the association of its choice of director.

(ii) Each designated advisory director has a vote on any matter coming before any meeting of the entire body of advisory directors for the §2203.301 fund or §2203.303 fund to which the advisory director has been designated. That vote will be weighted in the proportion that the net written premium collected during the most recent calendar year from policies issued to each category of §2203.301 fund health care provider and physician or §2203.303 fund for-profit or not-for-profit nursing home and assisted living facility bears to the total net written premiums collected from all categories of §2203.301 fund health care providers and physicians or to all categories of §2203.303 fund for-profit and not-for-profit nursing homes and assisted living facilities as applicable during the same calendar year. The proportion of weighting of the advisory directors' votes for the §2203.301 fund and the §2203.303 fund respectively must be determined annually by the association, not later than August 31.

(iii) The designated advisory directors for the §2203.301 fund and the §2203.303 fund respectively must meet not later than September 15 of each year, at a place in Texas stipulated by the board of directors to consider the amount of funds available and the status of the respective §2203.301 fund or §2203.303 fund. The designated advisory directors for the respective §2203.301 fund and §2203.303 fund must inform the board of directors of the percentage to be charged to all policyholders of all

policies issued or renewed by the association for the respective §2203.301 fund or §2203.303 fund during the next calendar year. This percentage must be communicated to the board of directors no later than September 20, annually.

(iv) If any organization described in clause (i) of this subparagraph fails to designate an advisory director, the directors designated by the remaining organizations constitute the entire body of advisory directors for the respective §2203.301 fund or §2203.303 fund, and their establishment of the respective §2203.301 fund or §2203.303 fund charge must be accepted as valid by the association and imposed pursuant to the operational procedures of the association, upon approval of the department.

(v) In the event that the advisory directors fail to establish a specific percentage charge for the respective §2203.301 fund or §2203.303 fund to be collected for the coming calendar year before the applicable deadline, the board of directors must immediately submit for approval by the Commissioner a charge to be collected from the respective §2203.301 fund or §2203.303 fund policyholders of each new and renewal policy during the upcoming calendar year in accordance with the provisions of the Insurance Code.

(vi) The advisory directors serve without salary or other fee, and they may not be reimbursed for any expenses. The advisory directors, in the performance of their duties, will be afforded the protection of §5.2002(h) of this title (relating to Operation of the Texas Medical Liability Insurance Underwriting Association).

(C) The respective §2203.301 fund or §2203.303 fund charge must be collected annually from each policyholder of the applicable §2203.301 or §2203.303 fund, as may be appropriate, and must be stated as a percentage of the annual premium due

for all coverages on all policies issued or renewed on or after the effective date of the charge. The percentage charge will remain in effect until changed in accordance with subparagraph (B) of this paragraph.

(D) The respective §2203.301 fund or §2203.303 fund charge must be separately stated in the policy, but may not constitute a part of premium or be subject to premium taxation, servicing fees, acquisition costs, commissions, or any other such charges. Further, the respective fund charge will not be considered premiums for the purpose of any assessments levied under subsection (d) of this section.

(E) The respective §2203.301 fund or §2203.303 fund charges must be collected and administered by the association and must be treated as a liability of the association along with and in the same manner as premium and loss reserves. The §2203.301 fund and the §2203.303 fund must be valued annually by the board of directors within 90 days of the last day of the preceding calendar year.

(F) Collections of the respective §2203.301 fund or §2203.303 fund charge must continue throughout each calendar year for which they are established, provided that no charge will be made during the next succeeding calendar year if the net balance in the respective fund after recoupment of any prior year's deficit equals or exceeds the association's estimate of the projected sum of premiums to be written in the calendar year following the valuation date of the respective fund.

(2) §2203.301 fund or §2203.303 fund charge. The respective proportionate §2203.301 fund or §2203.303 fund charge must be based on the total annual written premium for all coverages provided by the association to the applicable §2203.301 fund or §2203.303 fund policyholders. The respective §2203.301 fund or §2203.303 fund charges are not be refundable if the policy is cancelled after the 90th day of coverage. If

cancelled within the 90th day of coverage, the earned charge will be based on the same earned percentage charged for the insurance premium.

(3) Disbursements from the respective §2203.301 fund or §2203.303 fund. Disbursements from the respective §2203.301 fund or §2203.303 fund may not be made for any purpose other than to recoup a deficit from operations as defined in subsection (d) of this section. Upon suspension of the association by the Commissioner, any funds remaining in the §2203.301 fund must be added to the special fund created by the Commissioner, acting as receiver, or a special deputy receiver acting on behalf of the receiver. Any investment income earned on the funds of the §2203.301 fund must be added to that fund. Upon termination of the §2203.303 fund, all assets of the fund must be transferred as provided in the Act.

(d) Participation by members and policyholders of the association.

(1) Deficit and remedy of a deficit.

(A) The association must have sustained a deficit from operations whenever the aggregate of the incurred losses (reported and unreported), plus all loss adjustment expenses incurred, plus commissions and plus other administrative expenses (including servicing carrier fees) incurred by the association in a given calendar year, exceed the aggregate of the net premiums earned and other net income (including investment income earned) realized by the association in the same calendar year.

(B) Any deficits sustained by the association in any one calendar year with respect to any category of physicians or health care providers subject to Insurance Code §2203.101 or for-profit or not-for-profit nursing homes or assisted living facilities subject to Insurance Code §2203.102 must be recouped, pursuant to this subchapter and the rating plan in effect, by one or more of the following procedures in this sequence:

(i) first, a contribution from the §2203.301 fund or §2203.303 fund, as appropriate, until the respective fund is exhausted;

(ii) second, an assessment upon the policyholders pursuant to paragraph (3) of this subsection and Insurance Code §2203.252;

(iii) third, an assessment upon the members of the association pursuant to paragraph (4) of this subsection and Insurance Code §2203.053.

(2) Surplus and disposition of a surplus.

(A) The association must have sustained a surplus from operations whenever the aggregate of the incurred losses (reported and unreported), plus all loss adjustment expenses incurred, plus commissions and plus other administrative expenses (including servicing carrier fees) incurred by the association in a given calendar year, do not exceed the aggregate of the net premiums earned and other net income (including investment income earned) realized by the association in the same calendar year.

(B) Upon approval by the board of directors, surplus from operations must be ratably distributed as reimbursements to members who have been assessed pursuant to paragraph (4) of this subsection and have paid such assessments, but have not been previously reimbursed and have not been allowed the premium tax credit (offset) pursuant to subsection (e) of this section.

(C) Upon approval of the Commissioner, the association must reimburse the state to the extent that the members have recouped their assessments using premium tax credits pursuant to subsection (e) of this section, with interest at a rate to be approved by the Commissioner.

(D) Any balance remaining in the funds of the association at the close of its fiscal year, meaning its then excess of revenue over expenditures after approved

reimbursement of members' contributions, must be added to the reserves of the association.

(3) Participation by policyholders of the association.

(A) Assessment of policyholders; contingent liability. Each policyholder within either the §2203.301 fund or §2203.303 fund must have contingent liability for a proportionate share of any assessment of policyholders in the applicable §2203.301 fund or §2203.303 fund made by the association pursuant to Insurance Code §2203.252 and the provisions of the plan of operation set forth in this subchapter.

(B) Procedure for assessment of policyholders. Assessment of policyholders shall be made in accordance with the following:

(i) Notice of assessment must be sent by certified mail, return receipt requested, to each policyholder being assessed within 30 days of the board of directors meeting at which such assessment was levied. Notice must be forwarded to the address of each policyholder as it appears on the books of the association. The notice must state the policyholder's allocated amount of assessment and must inform each policyholder of the sanctions imposed by clause (ii) of this subparagraph for the failure to pay such assessment within the time prescribed by this section.

(ii) Each policyholder must remit to the association payment in full of an assessment within 30 days of receipt of notice of assessment. However, a policyholder that is not delinquent on any prior assessments, stabilization reserve fund charge, or premium may remit payment of an assessment levied for a deficit incurred in a calendar year in two installments with at least one-half of the assessment paid within 30 days after receipt of notice of assessment and the remaining balance paid within 30 days thereafter. If the association has not received payment of the policyholder's assessment

or any installment payment within 10 days after the payment is due, then the association must promptly cancel any policy of insurance that the policyholder at that time has in force with the association, and the association may offset any unearned premium otherwise refundable on such policy against the amount of that policyholder's unpaid assessment. Such cancellation of current insurance coverage will in no way affect the right of the association to proceed against the policyholder in any court of law or equity in the United States for any remedy provided by law or contract to the association, including, but not limited to, the right to collect the policyholder's assessment.

(4) Participation by members of the association.

(A) Assessment of members. Insurance Code Chapter 2203 provides that in the event that sufficient funds are not available for the sound financial operation of the association, in addition to assessments paid pursuant to the plan of operation set forth in this subchapter and contributions from the stabilization reserve funds, all members must, on a basis authorized by the Commissioner, as long as the Commissioner deems it necessary contribute to the financial requirements of the association in the manner provided for in this section and Insurance Code §2203.254. Any assessment or contribution must be reimbursed to the members as provided in Insurance Code §2203.255.

(B) Procedure for assessment of members.

(i) All insurers that are members of the association must participate in its writings, expenses, and losses in the proportion that the net direct premiums of each member, excluding that portion of premiums attributable to the operation of the association, written in this state during the preceding calendar year bears to the aggregate net direct premiums written in this state by all members of the

association during the same calendar year. Each insurer's participation in the association must be determined annually on the basis of net direct premiums written during the preceding calendar year as reported in the annual statements and other reports filed by that insurer that may be required by the department. No member may be obligated in any one year to reimburse the association on account of its proportionate share in the unrecouped deficit from operations of the association in that year in excess of 1.0% of its surplus to policyholders. The aggregate amount not reimbursed must be reallocated among the remaining members in accordance with the method of determining participation prescribed in this subsection, after excluding from the computation the total net direct premiums of all members not sharing in such excess deficit. In the event that the deficit from operations allocated to all members of the association in any calendar year exceeds 1.0% of their respective surplus to policyholders, the amount of the deficit must be allocated to each member in accordance with the method of determining participation prescribed in this subsection.

(ii) Notice of assessment must be sent by certified mail, return receipt requested, to each member within 30 days of the board of directors' meeting at which the assessment was levied. Notice shall be forwarded to the office address of the member as it appears on the books of the association. The notice must state the member's allocated amount of assessment and must inform each member of the sanctions imposed by clause (iii) of this subparagraph for the failure to pay the assessment within the time prescribed by this section.

(iii) Each member must remit to the association payment in full of its assessed amount within 30 days of receipt of notice of assessment. If the association has not received payment in full of a member's allocated amount of

assessment within 40 days of notice of the receipt by the member of the notice of assessment, then the association must report to the Commissioner the fact that the assessment has not been paid. The Commissioner may take such actions as are permitted under the Insurance Code, including, but not limited to, actions authorized by Insurance Code Chapter 82, to consider revocation of the certificate of authority of the delinquent member. Any action by the Commissioner will in no way affect the right of the association to proceed against the member in any court of law or equity in the United States for any remedy provided by law or contract to the association, including, but not limited to, the right to collect the member's assessment. A member, by mailing payment of its allocated amount of assessment as provided by this section, does not waive any right it may have to contest the computation of its allocated amount of assessment. A contest does not, however, toll the time in which the assessment must be paid, or the report is made to the Commissioner.

(5) Basis of computation of deficit, surplus, and assessments. The computation of the deficit or surplus in operations of the association and the computation of assessment of members and policyholders must be computed on a calendar-year basis in accordance with the reporting requirements of the annual statement filed with the department.

(e) Premium tax credit (offset) for member assessments. To the extent that a member has been assessed and has paid one or more assessments as contemplated by this subchapter and has not received reimbursement from the association for the assessments, that member, as provided for in Insurance Code §2203.251, must be allowed a credit against its premium taxes under Insurance Code Chapter 221, for all lines of insurance that the member is writing in Texas that are subject to a premium tax under

Insurance Code Chapter 221. The tax credit, in the aggregate amount of the assessments, plus interest at a rate to be approved by the Commissioner, must be allowed at a rate of 20% per year for five successive years following the year in which the deficit was sustained and, at the option of the member, may be taken over an additional number of years. For purposes of this premium tax offset, expense fees paid pursuant to §5.2002(b)(1) and (2) of this title (relating to Operation of the Texas Medical Liability Insurance Underwriting Association) are deemed to be assessments.

(f) Auditing of members. The association may audit the policies, records, book of accounts, documents, and related material of any member that are necessary to carry out its functions. Such material must be provided by the members in the form and with the frequency reasonably required by rules adopted by the Commissioner.

§5.2004. Medical Liability Insurance and General Liability Insurance.

(a) The policy.

(1) Approval. The procedures regarding rates, rating plans, rating rules, rating classifications, territories, and policy forms applicable to insurance written by the association and related statistics must comply with Insurance Code Chapter 2203, Subchapter E.

(2) Duration of policies.

(A) All policies issued by the association must be written for a term of one year or less, as determined by the association, to begin at 12:01 a.m. on their respective effective dates.

(B) The association may not issue a policy with an effective date after a date set under Insurance Code Article 21.49-3, §11 for a plan of suspension to become effective and operative.

(C) All policies must be written on forms approved by the department, and must contain a provision that requires, as a condition precedent to settlement or compromise of any claim, the consent or acquiescence of the insured. If, however, the insured refuses to consent to any settlement recommended in writing by the association and elects to contest or continue any legal proceedings, the liability of the association must not exceed the amount for which the claim could have been settled plus the cost and expenses incurred up to the date of the refusal.

(3) Installment payment plan. The association may offer an installment plan for coverage obtained through the association or for payment of the stabilization reserve fund charge. The association may require the policyholder to pay the stabilization reserve fund charge as an annual lump sum.

(4) Limits of liability.

(A) No individual or organization may be insured by a policy issued, or caused to be issued, by the association for an amount exceeding a total of $1 million per occurrence (for all coverages combined) and $3 million aggregate per annum (for all coverages combined). As used in this paragraph, the terms "individual" and "organization" mean each physician, health care provider, health care practitioner, and health care facility holding a separate license or accreditation from the appropriate licensing or accrediting agency as applicable.

(B) If provided, general liability limits must be the same as medical liability limits subject to the maximum policy limits specified in subparagraph (A) of this paragraph.

(5) Special provisions.

(A) The association may issue policies with deductibles.

(B) The association may issue policies subject to retrospective rating plans.

(C) Policies of excess medical liability insurance and excess general liability insurance written by the association must:

(i) be on a following form basis to the underlying medical liability insurance or underlying general liability insurance coverage over which it is written;

(ii) be issued subject to review of the underlying coverage if review is deemed necessary by the association or its representatives;

(iii) not be issued in those cases where the net retention at risk by the primary carrier is less than $100,000 per occurrence or less than $300,000 aggregate per annum after applying any applicable deductible;

(iv) be issued only when the underlying insurance coverage is underwritten by a member of the association and the underlying insurance coverage does not have a deductible in excess of $25,000;

(v) terminate automatically if the underlying primary medical liability insurance policy or underlying primary general liability insurance is not maintained for any reason, except exhaustion by payment of a loss or losses. If the aggregate underlying primary medical liability insurance or general liability insurance is exhausted

by the payment of a loss or losses occurring during the policy period, the insurance provided by the excess policy must apply in the same manner as if the underlying primary insurance was in full force and effect;

(vi) not be accepted for a hospital or other institutional health care provider or health care facility if the applicant does not provide evidence that all physicians, surgeons, podiatrists, dentists, pharmacists, chiropractors, or other health care providers or health care practitioners with staff privileges are insured for their individual medical liability with limits of liability of at least $100,000 per occurrence and $300,000 aggregate per annum; and

(vii) not be accepted for physicians, surgeons, podiatrists, dentists, pharmacists, chiropractors, or other health care providers or health care practitioners who employ or contract with other physicians, surgeons, podiatrists, dentists, pharmacists, chiropractors, or other health care providers or health care practitioners if the applicant does not provide evidence that all employed physicians, surgeons, podiatrists, dentists, pharmacists, chiropractors, or other health care providers or health care practitioners who are eligible to obtain coverage from the association are insured for their individual medical liability with limits of liability of at least $100,000 per occurrence and $300,000 aggregate per annum.

(D) No hospital or other institutional health care provider, health care facility or physicians, surgeons, podiatrists, dentists, pharmacists, chiropractors, or other health care providers or health care practitioners that have employed or contracted physicians, surgeons, podiatrists, dentists, pharmacists, chiropractors, or other health care providers or health care practitioners can be accepted for coverage in the association without evidence that all physicians, surgeons, podiatrists, dentists, pharmacists,

chiropractors, or other health care providers, or health care practitioners with staff privileges or employed or contracted by the applicant are insured for their individual medical liability with limits of at least $100,000 per occurrence and $300,000 aggregate per annum.

(E) For purposes of this section, the term "health care providers or health care practitioners" does not include personnel at or below the level of employed registered nurse. Insurance required for physicians, surgeons, podiatrists, dentists, pharmacists, chiropractors, health care practitioners, or other health care providers with hospital staff privileges or employed or contracted by the applicant must be limited to any one of the following entities:

(i) an insurance company authorized and licensed to write and writing health care liability or medical liability insurance in Texas under Insurance Code Chapter 801;

(ii) an insurance company eligible to write and writing health care liability or medical liability insurance in Texas as a surplus lines carrier under Insurance Code Chapter 981;

(iii) the Texas Medical Liability Insurance Underwriting Association, established under Insurance Code Chapter 2203;

(iv) a self-insurance trust created to provide health care liability or medical liability insurance, established under Insurance Code Chapter 2212;

(v) a risk retention group or purchasing group writing health care liability or medical liability insurance in Texas, registered under Insurance Code Chapter 2201;

(vi) a plan of self-insurance of an institution of higher education that provides health care liability or medical liability coverage, established under Education Code Chapter 59; or

(vii) a plan of self-insurance that meets each of the following criteria:

(I) the plan's liabilities must be fully funded, and the plan must be solvent. The plan must have a minimum net worth equal to the lesser of $1 million or that amount of net worth that results in a capitalization ratio of 5%. As used in this subclause, "net worth" is calculated by determining the excess, if any, of the plan's total assets over the plan's total liabilities. As used in this subclause, "capitalization ratio" means the ratio of the plan's net worth (as the numerator) to the plan's total assets (as the denominator). Notwithstanding the preceding, the net worth requirements in this subclause do not apply to a plan that lawfully has taxing authority over a segment of the Texas public, provided that the taxing authority may be used to meet the plan's liabilities and other obligations;

(II) the plan must annually obtain from a qualified actuary who is a member in good standing of the American Academy of Actuaries an actuarial analysis that reflects that its operations are viable. Notwithstanding the preceding, an actuarial opinion filed with the department under Insurance Code §802.002 may be accepted for purposes of this subsection;

(III) financial statements of the plan must annually be audited by an independent certified public accountant who is a member in good standing of the American Institute of Certified Public Accountants (AICPA). The audits must use generally accepted auditing standards and must result in a report that attests to whether

the financial statements comply with generally accepted accounting principles adopted by the AICPA. Notwithstanding the preceding, an audit report filed with the department under Insurance Code Chapter 401 may be accepted for purposes of this subsection; and

(IV) the plan must have competent and trustworthy management who are generally knowledgeable of insurance matters. A plan is not eligible if a plan officer or member of the plan's board of directors or similar governing body has been convicted of a felony involving moral turpitude or breach of fiduciary duty.

(6) Rates, rating plans, and rating rules applicable. The rates, rating plans, rating rules, rating classifications, and territories applicable must be those established under Insurance Code Chapter 2203, Subchapter E.

(b) Application, underwriting standards, and acceptance or rejection.

(1) Eligibility and forms.

(A) Any physician and any health care provider as defined in Insurance Code §2203.002 and any health care practitioner and health care facility as defined in Insurance Code §2203.103 that falls within any of the categories of physicians, health care providers, health care practitioners, or health care facilities established by order of the Commissioner from time to time as being eligible to obtain coverage from the association is entitled to apply to the association for a medical liability insurance policy. However, if the applicant is a partnership, professional association, or corporation (other than a nonprofit corporation certified under Occupations Code Chapter 162) composed of eligible health care providers or health care practitioners (such as physicians, dentists, or podiatrists), all of the partners, professional association members, or shareholders must also be individually insured in the association.

(i) Any category of physician or health care provider, which by order of the Commissioner has been excluded from eligibility to obtain coverage from the association, may be eligible for coverage in the association if, after at least 10 days' notice and an opportunity for a hearing, the Commissioner determines that medical liability insurance is not available for the category of physician or health care provider. In addition, a for-profit or not-for-profit nursing home or assisted living facility not otherwise eligible for coverage from the association is eligible for coverage if the nursing home or assisted living facility demonstrates, in accordance with the requirements of the association, that the nursing home or assisted living facility made a verifiable effort to obtain coverage from authorized insurers and eligible surplus lines insurers and was unable to obtain substantially equivalent coverage and rates.

(ii) All applications for medical liability and general liability insurance must be made on forms prescribed by the board of directors of the association and approved by the department. The application forms must contain a statement as to whether or not there are any unpaid premiums, assessments, or stabilization reserve fund charges due from the applicant for prior insurance. Application may be made on behalf of the applicant by an agent authorized under Insurance Code Chapter 4051. The agent need not be appointed by a servicing company.

(B) The association may issue a general liability insurance policy to an applicant specified in subparagraph (A) of this paragraph only if the association issues to that applicant a medical liability insurance policy.

(2) Licensed agent. If a liability insurance policy is written through a licensed agent, then:

(A) the commission paid to the licensed agent must be 10% of the first $1,000 of the policy premium, 5% of the next $9,000 of the policy premium, and 2% of the policy premium in excess of $10,000 for policies written by the association on the form approved for physicians and noninstitutional health care providers;

(B) the commission paid to the licensed agent must be 12.5% of the first $2,000 of the policy premium, 7.5% of the next $3,000 of the policy premium, 5% of the next $15,000 of the policy premium, and 2% of the policy premium in excess of $20,000 for policies written by the association on the form approved for hospitals and other institutional health care providers;

(C) the commission paid to the licensed agent must be 10% of the policy premium for an excess liability insurance policy written by the association for a physician or any other health care provider as defined in Insurance Code §2203.002. The commission, however, may not exceed $250 for a policy written on the form approved for physicians and other noninstitutional health care providers, and may not exceed $500 for a policy written on the form approved for hospitals and other institutional health care providers; and

(D) no commission may be payable for any assessment payable by the policyholder by reason of a deficit incurred by the association, including charges for the stabilization reserve funds. On cancellation, the agent must refund any unearned portion of the commission to the association.

(3) Submission. Application for medical liability or general liability insurance on the prescribed form must be accompanied by tender of the amount of the deposit premium and the charge for the stabilization reserve fund required to bind the policy.

(4) Underwriting standards.

(A) On initial application and every reapplication to the association, the following underwriting standards must apply for policies of medical liability insurance written by the association:

(i) all applicants to the association must be currently licensed, chartered, certified, or accredited to practice or provide their respective health care services in Texas;

(ii) all health care provider, practitioner and facility and physician applicants to the association must provide evidence of inability to obtain medical liability coverage. The evidence must be two written rejections by carriers licensed and engaged in writing the coverage applied for in Texas or by a self-insurance trust created under Insurance Code Chapter 2212;

(iii) all for-profit and not-for-profit nursing home and assisted living facility applicants to the association must provide evidence of inability to obtain coverage from authorized insurers and eligible surplus lines insurers for substantially equivalent coverage and rates. The evidence must be two written rejections by insurers licensed and engaged in writing the coverage applied for in Texas or by eligible surplus lines insurers. For purposes of this subsection, a rejection has occurred if the applicant:

(I) made a verifiable effort to obtain insurance coverage from authorized insurers and eligible surplus lines insurers; and

(II) was unable to obtain substantially equivalent insurance coverage and rates.

(iv) any material misrepresentation in the application for coverage must be cause to decline coverage on discovery by the association or its authorized representative;

(v) each application must be accompanied by authorization for and consent to investigations of material information bearing on the moral character, professional reputation, and fitness to engage in the activities embraced by the applicant's license with respect to applicants who are to be provided coverage on the form approved for physicians and noninstitutional health care providers, or the reputation, method of operation, accident prevention programs, and fitness to engage in the activities embraced by the applicant's license, charter, certificate, or accreditation for applicants who are to be provided coverage on the form approved for hospitals and other institutional health care providers, including authorization to every person or entity, public or private, to release to the association any documents, records, or other information bearing on this information;

(vi) no coverage may be afforded either by binder or by policy issuance to any applicant whose license, charter, certificate, or accreditation has been ordered canceled, revoked, or suspended, provided that, if the order has been probated by the appropriate regulatory body or licensing agency, then the probation may be reviewed by the association for a determination whether and on what basis coverage may be afforded in the association;

(vii) the applicant, to be eligible for coverage in the association, must comply with all significant recommendations arising out of a loss control or risk management report either before binding coverage or as soon as practicable concurrently with coverage;

(viii) there must be no unpaid, uncontested premium; assessment; or charge due from the applicant; and

(ix) there must be no unpaid deductible, in whole or part, owed to the association.

(5) Receipt of the application. On receipt of the application, the required deposit premium, and the applicable stabilization reserve fund charge, the association must, within 30 days:

(A) cause a binder or insurance policy to be issued; or

(B) advise the agent or applicant that the applicant does not meet the underwriting standards of the association, in which case the association must indicate the reasons the applicant does not meet the underwriting standards.

(c) Cancellation, nonrenewal, and notice.

(1) Cancellation by the association. The association may not cancel an insurance policy except for:

(A) nonpayment of premium;

(B) nonpayment of the applicable stabilization reserve fund charge;

(C) nonpayment of assessment;

(D) evidence of fraud or material misrepresentation;

(E) cause that would have been grounds for nonacceptance of the risk under this subchapter had the cause been known to the association at the time the policy was issued;

(F) any cause arising after the policy is issued that would have been grounds for nonacceptance of the risk under this subchapter had the cause existed at the time of acceptance; or

(G) noncompliance with reasonable loss control or risk management recommendations under subsection (b)(4)(A)(vii) of this section. On cancellation of an

insurance policy by the association, the association must refund to the insured the unearned portion of any paid premium and, if canceled within the 90th day of coverage, the unearned portion of the paid fund charges under Insurance Code Chapter 2203, Subchapter G on a pro rata basis, provided that all assessments and fund charges earned under Insurance Code Chapter 2203, Subchapter G have been fully paid; otherwise, only that portion of unearned premium over any unpaid assessment and fund charges under Insurance Code Chapter 2203, Subchapter G will be refunded. Policyholder assessments and fund charges under Insurance Code Chapter 2203, Subchapter G are fully earned on payment; therefore, except as provided in Insurance Code Chapter 2203 or §5.2003(c)(2) of this title (relating to Members and Policyholders Participation in the Texas Medical Liability Insurance Underwriting Association), no portion is refundable.

(2) Cancellation by the insured. An insurance policy may be canceled at any time:

(A) by the insured, on written request for cancellation of the policy; or

(B) by an insurance premium finance company in accordance with Insurance Code Chapter 651.

(3) Refund of unearned portion of paid premium. The association must refund the unearned portion of any paid premium and, if canceled within the 90th day of coverage, the unearned portion of the paid fund charges under Insurance Code Chapter 2203, Subchapter G according to the approved short-rate table, provided all assessments and fund charges under Insurance Code Chapter 2203, Subchapter G earned have been fully paid; otherwise, only that portion of the unearned premium over any unpaid assessment and fund charges under Insurance Code Chapter 2203, Subchapter G will be

refunded. Policyholder assessments and fund charges under Insurance Code Chapter 2203, Subchapter G are fully earned on payment; therefore, except as provided in Insurance Code Chapter 2203 or §5.2003(c)(2) of this title, no portion is refundable.

(4) Exhausted policy limits. If there is an outstanding claim or claims under any insurance policy on which a reserve or reserves have been established, which in the aggregate or when combined with losses previously paid under the policy equal or exceed the aggregate limits of coverage under the policy, the association must notify the insured. At the insured's option, the policy may be canceled. If the policy is canceled, the premium must be considered fully earned and the insured may apply for a new policy to be effective concurrently with the termination date of the canceled policy.

(5) Notice of cancellation, nonrenewal, or premium increase.

(A) The association may cancel a medical liability insurance policy and general liability insurance policy, or decline to renew a policy for any reason listed in paragraph (1) of this subsection at any time within the first 90 days from the effective date of the policy by sending 90 days written notice to the insured.

(B) The association may cancel a medical liability insurance policy and general liability insurance policy or decline to renew a policy for nonpayment of premium, assessments, or fund charges under Insurance Code Chapter 2203, Subchapter G, or for loss of license, charter, certification, or accreditation at any time during the policy period by sending 10 days' written notice to the insured.

(C) Notice of cancellation or nonrenewal under subparagraphs (A) and (B) of this paragraph must contain a statement of the reason for the cancellation or nonrenewal and a statement that the insured has the right to appeal under Insurance Code Chapter 2203, Subchapter I.

(D) The association must give at least 90 days' written notice to an insured before increasing the premium by reason of a rate increase on the insured's medical liability insurance policy. The notice must state the amount of the increase.

(6) General liability insurance. A general liability insurance policy issued by the association under Insurance Code §2203.151(b) automatically terminates on the same effective date and time as the termination of the medical liability insurance policy.

(d) Suspension of policy. The association must, on written request from a policyholder subject to the Servicemembers Civil Relief Act of 2003 (50 United States Code App. §§501, et seq.), suspend the policy issued by the association, in accordance with the Servicemembers Civil Relief Act of 2003.

(e) Removal of risks. Any member, or self-insurance trust established under Insurance Code Chapter 2212, at any time, on written consent from the insured filed with the association, may write the risk as regular business, in which event the association must cancel its policy pro rata as of a date and time specified by the manager of the association. The association will require written confirmation that the member or self-insurance trust is taking the risk out of the association before allowing pro rata cancellation.

(f) Payment of claims.

(1) Report of loss. All losses must be reported to the association in the manner prescribed by the board of directors.

(2) Adjustment of loss. All losses must be adjusted in the manner designated by the board of directors subject to the provisions of this plan of operation and the insurance laws of Texas.

§5.2005. Amendments.

Amendments to this subchapter may be recommended by the board of directors, subject to the approval of the Commissioner, or may be made at the direction of the Commissioner.

§5.2006. Reinsurance.

Pursuant to Insurance Code §2203.151(a)(3) and (4), the Texas Medical Liability Insurance Underwriting Association may cede and purchase reinsurance. The purpose of this section is to implement Insurance Code §2203.151(a)(3) and (4).

(1) The association may develop a reinsurance program that will provide for the purchase of reinsurance and that will maintain the purpose of the association to provide medical liability insurance and general liability insurance on a self-supporting basis.

(2) A reinsurance program is subject to prior approval by the Commissioner, and such prior approval must be obtained before implementation of the reinsurance program. The program must include, but is not limited to, the proposed reinsurance program structure and terms, including the reinsurance proposal and proposed reinsurance contract terms and conditions; cost of the proposed reinsurance program; the recommended percentage of reinsured business to be assumed by each individual reinsurer; a summary of the financial condition of each recommended reinsurer; the association's costs to administer the reinsurance program; compliance with Subchapter F of Chapter 7 of this title (relating to Reinsurance), to the extent that provisions do not conflict with this section or Chapter 2203 of the Insurance Code, or unless such provisions are waived by the Commissioner; and any other information the Commissioner deems necessary to enable the Commissioner to determine whether to approve or disapprove

the reinsurance program. The association must submit to the Commissioner, no later than 90 days before expiration of the reinsurance contract, the proposed renewal reinsurance program or a statement of the reasons why a reinsurance program is no longer necessary.

(3) The association must submit written notice of any amendment to any existing reinsurance contract to the Commissioner at least 60 days prior to the effective date of the proposed amendment. The notice must include an explanation of the reason for the amendment and a copy of the draft amendment. The amendment will be deemed approved by the Commissioner unless within 60 days following the submission of the written notice the Commissioner disapproves the amendment.

CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on 8/27/2020.

DocuSigned by:
James Person
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James Person, General Counsel
Texas Department of Insurance

The Commissioner adopts amendments to 28 TAC §§5.2001–5.2006.

DocuSigned by:
Kent Sullivan
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Kent C. Sullivan
Commissioner of Insurance

Commissioner's Order No. **2020-6452**