SUBCHAPTER C. TEXAS MEDICAL LIABILITY INSURANCE UNDERWRITING ASSOCIATION
28 TAC §5.2004

INTRODUCTION. The Texas Department of Insurance proposes to amend 28 TAC §5.2004, relating to the Texas Medical Liability Insurance Underwriting Association's (JUA) Plan of Operation (Plan). These amendments are necessary to help the JUA efficiently operate as the residual market for medical liability insurance.

EXPLANATION. The Texas Legislature formed the JUA in 1975 to be the residual market for medical liability insurance. Senate Bill 18, 84th Legislature, Regular Session (2015) enacted Insurance Code Chapter 2203, Subchapter J, which requires the commissioner to determine whether a necessity exists to suspend the JUA's authority to issue new insurance policies.

To evaluate the JUA in response to SB 18, TDI requested information from the JUA on its operations and current policyholders. After reviewing the information, TDI determined that amendments to the Plan are necessary. TDI proposes four amendments to the Plan to help the JUA operate more efficiently as a residual market:

1. Require that eligibility be based on two written rejections by carriers.
2. Require that eligibility for reapplication be based on two written rejections by carriers.
3. Remove as a reason for rejection rates from a carrier that are higher than JUA.
4. Prohibit accepting applicants that owe deductibles to the JUA.

The proposal will also update §5.2004(a)(2). Currently, the provision states that the JUA may not issue policies after the date fixed in the Texas Medical Liability Insurance Association Act for a plan of suspension to become effective and operative. The date fixed in the Act was December 31, 1985. No plan of suspension became effective on that date; therefore, that part of the section is obsolete. The amendment updates the section to remove the reference to the date but retains the requirement that if the JUA is suspended it cannot issue a policy with an effective date later than the date of suspension.

The proposal includes updates to citations to the Insurance Code to reflect changes made by the nonsubstantive recodification of the Insurance Code by House Bill 2922, 78th Legislature, Regular Session (2003) and HB 2017, 79th Legislature, Regular Session (2005). The proposal also includes nonsubstantive editorial and formatting changes to conform the rule text to TDI's current writing style and improve the rule's clarity.

Discussion of Proposed Amendments

1. Require that eligibility be based on two written rejections by carriers. TDI proposes to amend 28 TAC §5.2004(b)(4)(A)(ii) and §5.2004(b)(4)(A)(iii) to specify a single way that an applicant may show the inability to obtain coverage: by submitting written rejections from two voluntary market carriers. A carrier may be an insurer or a self-insurance trust created under Insurance Code Chapter 2212 (formerly Insurance Code Article 21.49-4).

Currently, under §5.2004(b)(4)(A)(ii) and §5.2004(b)(4)(A)(iii), applicants seeking coverage from the JUA must provide evidence that they are unable to obtain coverage in the voluntary market. Evidence includes two rejections from carriers that provide the type of coverage applied for, and the rejections may be shown by valid notification from the carriers or by sworn affidavit of the applicant or applicant's agent.

The JUA's purpose is to serve as the residual market for medical liability insurance, available for licensed physicians and health care providers that cannot obtain coverage in the voluntary market. Requiring applicants to provide two written rejections as proof of the inability to obtain coverage will help ensure that the JUA will accept only applicants eligible for coverage. Additionally, this will enable the JUA to document this information for each applicant.

2. Require that eligibility for reapplication be based on two written rejections by carriers. Currently, §5.2004(b)(4)(A)(ii) and §5.2004(b)(4)(A)(iii) require applicants to show their inability to obtain coverage from the voluntary market. In practice, the JUA requires this proof on reapplication, but that requirement is not currently in the Plan.

TDI proposes amending the Plan to require that applicants show their inability to obtain coverage every time they reapply to the JUA. Policyholders must reapply at the end of their policy term. This amendment requires applicants, on each reapplication for a policy, to go through the same process that is required on their initial application. The JUA's purpose is to be a residual market; therefore, an applicant should have to provide proof of rejection each time they apply for coverage, regardless of their prior coverage in the JUA.

3. Remove as a reason for rejection rates from a carrier that are higher than JUA. TDI proposes amending the Plan so that, when determining eligibility for JUA coverage, an applicant is not considered rejected from a carrier if they are accepted in the voluntary market at a rate higher than that available from the JUA. Currently, under §5.2004(b)(4)(B), it is considered a rejection if the applicant is accepted

in the voluntary market at a higher rate than the rate offered by the JUA. The JUA's function is to operate as a residual market, not to be in price competition with the voluntary market. Therefore, higher price should not be considered a rejection.

The amendment to remove higher rates from carriers as a reason for rejection does not apply to nursing homes and assisted living facilities. Insurance Code §2203.102 and 28 TAC §5.2004(b)(4)(A)(iii) require that nursing homes and assisted living facilities show the inability to obtain substantially equivalent coverage and rates. Accordingly, they may still consider a higher price from a carrier in the voluntary market as a rejection from that carrier.

4. Prohibit accepting applicants that owe deductibles. TDI proposes to amend the JUA's underwriting standards by adding new §5.2004(b)(4)(A)(ix) to prohibit the JUA from accepting applicants that owe the JUA all or part of a deductible. Insurance Code §2203.104 and 28 TAC §5.2004(b)(4)(A)(viii) require that an applicant have no unpaid, uncontested premium or assessment due for prior insurance. Amending the Plan to include unreimbursed deductibles will similarly allow the JUA to decline coverage to applicants that owe the JUA all or part of a deductible.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Marianne Baker, director of the Property and Casualty Personal Lines Office, has determined that for each year of the first five years the proposed amendments are in effect, there will be no measurable fiscal impact on state and local governments as a result of the enforcement or administration of this proposal. Additionally, Ms. Baker does not anticipate a measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments are in effect, Ms. Baker expects that enforcing or administering the proposed amendments will have the public benefits of ensuring that the JUA is operating as a residual market and ensuring that licensed medical providers seek coverage in the voluntary market before applying to the JUA.

Ms. Baker expects that the proposed amendments will not impose costs on the JUA beyond current underwriting costs. The JUA must currently verify eligibility before providing coverage; this rule simply changes some of the eligibility criteria.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. As required by Government Code §2006.002(c), TDI has determined that the proposed

amendments will not have an adverse economic effect on small or micro businesses because the proposal does not apply to any small or micro businesses. The proposed amendments update provisions in the Plan that the JUA must follow, and the JUA is not a small or micro business under Government Code §2006.002.

TAKINGS IMPACT ASSESSMENT. TDI 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. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. Submit any written comments on the proposal no later than 5 p.m., Central time, on Monday, July 24, 2017. TDI requires two copies of your comments. Send one copy by email to ChiefClerk@tdi.texas.gov; or by mail to the Office of the Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. Send the other copy by email to CommercialPC@tdi.texas.gov; or by mail to Kimberly Donovan, Manager, Property and Casualty Lines Office, Regulatory Policy Division, Mail Code 104-PC, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

Written and oral comments on the proposal will be considered in a public hearing under Docket No. 2799 at 9:30 a.m., Central time, on Friday, July 7, 2017, in Room 100 of the William P. Hobby Jr. State Office Building, 333 Guadalupe Street, Austin, Texas.

STATUTORY AUTHORITY. TDI proposes amendments to 28 TAC §5.2004 under Insurance Code Article 21.49-3, Sec. 12 and Sec. 13; and Insurance Code §§2203.053, 2203.054, 2203.101, 2203.102, 2203.104, and 36.001.

Insurance Code Article 21.49-3, Sec. 12, provides that at any time TDI finds that the association is no longer needed to accomplish the purposes for which it was created, TDI may issue an order suspending the association as of a certain date stated in the order.

Insurance Code Article 21.49-3, Sec. 13, provides that if TDI issues an order suspending the association, no policies may be issued by the association after the date of suspension.

Insurance Code §2203.053 requires that the plan of operation contain provisions relating to the establishment of necessary facilities; the association’s management; the assessment of members and

policyholders to defray losses and expenses; the administration of the policyholder's stabilization reserve funds; commission arrangements; reasonable and objective underwriting standards; the acceptance, assumption, and cession of reinsurance; the appointment of servicing insurers; and procedures for determining amounts of insurance to be provided by the association.

Insurance Code §2203.054 allows the commissioner to direct amendments to the association's plan of operation.

Insurance Code §2203.101 directs the commissioner to establish by order the categories of physicians and health care providers that are eligible to obtain insurance coverage from the association.

Insurance Code §2203.102 provides that a nursing home or assisted living facility not otherwise eligible for coverage under Insurance Code §2203.101 is eligible for that coverage if it can show it made a verifiable effort to obtain coverage from a carrier in the voluntary market and was unable to obtain substantially equivalent coverage and rates.

Insurance Code §2203.104 states that a physician or health care provider included in a category eligible for insurance coverage by the association is entitled to apply to the association for coverage. On receipt of the premium and the policyholder's stabilization reserve fund charge, the association must issue a medical liability insurance policy if the association determines that the applicant meets the underwriting standards of the association prescribed by the plan of operation, and there is no unpaid and uncontested premium, charge, or assessment due from the applicant.

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.

CROSS-REFERENCE TO STATUTE. 28 TAC §5.2004 implements Insurance Code Article 21.49-3, Sec.12 and Sec. 13, and Insurance Code §§2203.053, 2203.054, 2203.101, 2203.102, and 2203.104.

TEXT.

SUBCHAPTER C. TEXAS MEDICAL LIABILITY INSURANCE UNDERWRITING ASSOCIATION

§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 [~~relating thereto shall be in accord~~] with Insurance Code Chapter 2203, Subchapter E [~~the Act, §4~~].

(2) Duration of policies.

(A) All policies issued by the association must [~~shall~~] be written for a term of one year or less, as determined by the association, to begin [~~commence~~] at 12:01 a.m. on their respective effective dates. [~~No policies may be issued by the~~]

(B) The association may not issue a policy with an effective date after a [~~the~~] date set under Insurance Code Article 21.49-3 [~~fixed in the Act~~] for a plan of suspension to become effective and operative.

(C) All policies must [~~shall~~] be written on [~~upon~~] forms approved by the department, and must [~~shall~~] contain a provision that [~~which~~] 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 [~~shall~~] not exceed the amount for which the claim could have been settled plus the cost and expenses incurred up to the date of the [~~such~~] 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 [~~Policies~~] with deductibles [~~may be issued by the association~~].

(B) The association may issue policies [~~Policies~~] subject to retrospective rating plans [~~may be issued by the association~~].

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

(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 [~~the application of~~] any applicable deductible;

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

(v) terminate automatically if [~~in the event~~] the underlying primary [~~policy of~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~pursuant to the authority of the~~] 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 [~~pursuant to the authority of the~~] Insurance Code[~~,~~] Chapter 981;

(iii) the Texas Medical Liability Insurance Underwriting Association, established under [~~the~~] Insurance Code Chapter 2203 [~~Article 21.49-3~~];

(iv) a self-insurance trust created to provide health care liability or medical liability insurance, established under [~~the~~] Insurance Code Chapter 2212 [~~Article 21.49-4~~];

(v) a risk retention group or purchasing group writing health care liability or medical liability insurance in Texas, registered under [~~, pursuant to the authority of the~~] Insurance Code Chapter 2201 [~~Article 21.54~~];

(vi) a plan of self-insurance of an institution of higher education that provides health care liability or medical liability coverage, established under [~~the~~] 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 percent [~~5.0%~~]. As used in this subclause, "net worth" is [~~shall be~~] 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 [~~contained~~] 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 [~~utilized~~] to meet the plan's liabilities and other obligations; and

(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 [~~which~~] reflects that its operations are viable [~~from a qualified actuary who is a member in good standing of the American Academy of Actuaries~~]. Notwithstanding the preceding, an actuarial opinion filed with the department [~~Texas Department of Insurance~~] under [~~pursuant to Texas~~] Insurance Code [~~Article~~] §802.002 may be accepted for purposes of this subsection; and

(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 [~~utilize~~] generally accepted auditing standards and must result in a report that [~~which~~] attests to whether the financial statements comply with generally accepted accounting principles [~~principals~~] adopted by the AICPA. Notwithstanding the preceding, an audit report filed with the department [~~Texas Department of Insurance~~] under [~~pursuant to Texas~~] Insurance Code Chapter 401 [~~Article 1.15A~~] may be accepted for purposes of this subsection; and

(IV) the plan must have competent and trustworthy management who are [~~is~~] generally knowledgeable of insurance matters. [~~In no event shall a~~] A plan is not [~~be~~] 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 [~~shall~~] be those established under Insurance Code Chapter 2203, Subchapter E [~~pursuant to the Act, §4~~].

(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 [~~(as defined in the Act, §2)~~] and any health care practitioner and health care facility as defined in Insurance Code §2203.103 that [~~(as defined in the Act, §3B) which~~] 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 [~~shall be~~] entitled to apply to the association for a [~~policy of~~] medical liability insurance policy. [~~, provided, that if~~] However, if the applicant is a partnership, professional association, or corporation (other than a nonprofit corporation certified under Occupations Code Chapter 162[~~, Occupations Code~~]) comprised 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, [~~it is determined by~~] 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 [~~shall~~] be made on forms prescribed by the board of directors of the association and approved by the department. The application forms must [~~shall~~] 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

[~~pursuant to the~~] Insurance Code Chapter 4051 [~~Article 21.14~~]. The [~~Such~~] 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 [~~is issued~~] a medical liability insurance policy [~~by the association~~].

(2) Licensed agent. If a [~~policy of~~] liability insurance policy is written through a licensed agent then:

(A) the commission paid to the licensed agent must [~~shall~~] be 10 percent [~~10%~~] of the first $1,000 of the [~~such~~] policy premium, 5 percent [~~5.0%~~] of the next $9,000 of [~~such~~] the policy premium [~~premiums~~], and 2 percent [~~2.0%~~] of the policy premium in excess of $10,000 for [~~with respect to~~] 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 [~~shall~~] be 12.5 percent [~~12.5%~~] of the first $2,000 of the [~~such~~] policy premium, 7.5 percent [~~7.5%~~] of the next $3,000 of the [~~such~~] policy premium, 5 percent [~~5.0%~~] of the next $15,000 of the [~~such~~] policy premium, and 2 percent [~~2.0%~~] of the policy premium in excess of $20,000 for [~~with respect to~~] policies written by the association on the form approved for hospitals and other institutional health care providers;

(C) [~~with respect to an excess liability insurance policy written by the association for a physician or any other health care provider (as those terms are defined in the Act)~~] the commission paid to the licensed agent must [~~shall~~] be 10 percent [~~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. [~~, provided, however, that the~~] The commission, however, may [~~shall~~] not exceed $250 for [~~with respect to~~] a policy written on the form approved for physicians and other noninstitutional health care providers, and may [~~shall~~] not exceed $500 for [~~with respect to~~] a policy written on the form approved for hospitals and other institutional health care providers; and

(D) no commission may [~~shall~~] be payable for [~~in respect to~~] any assessment payable by the policyholder by reason of a deficit incurred by the association, including charges for the stabilization reserve funds. On [~~Upon~~] cancellation, the agent must [~~shall~~] 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 [~~shall~~] 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 [~~The~~] following underwriting standards must [~~shall~~] apply for [~~with respect to~~] policies of medical liability insurance written by the association:

(i) all applicants to the association must [~~shall~~] 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 [~~shall~~] provide evidence of inability to obtain medical liability coverage. The evidence must be two [~~Two~~] written rejections by carriers [~~, including insurers~~] licensed and engaged in writing the coverage applied for in Texas or by a self-insurance trust created under Insurance Code Chapter 2212 [~~Article 21.49-4, shall be deemed adequate to show inability and rejections may be evidenced by valid notification from the insurers or trust or by sworn affidavit of the applicant or the applicant's agent that the rejections have occurred~~];

(iii) all for-profit and not-for-profit nursing home and assisted living facility applicants to the association must [~~shall~~] 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 [~~Two~~] written rejections by insurers licensed and engaged in writing the coverage applied for in Texas or by eligible surplus lines insurers. [~~shall be deemed adequate to show inability and rejections may be evidenced by valid notification from the insurers or by sworn affidavit of the applicant or the applicant's agent that the rejections have occurred;~~] 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 [~~shall~~] be cause to decline coverage on [~~upon~~] discovery by the association or its authorized representative;

(v) each application must [~~shall~~] be accompanied by authorization for and consent to investigations of material information bearing on [~~upon~~] 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 [~~with respect to~~] applicants that [~~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 [~~upon~~] 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 [~~cancelled~~], revoked, or suspended; provided [~~,~~] that, if the order has been probated by the appropriate regulatory body or licensing agency, 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 [~~shall~~] comply with all significant recommendations arising out of a loss control or risk management report either before [~~prior to~~] binding coverage or as soon as practicable concurrently with coverage;

(viii) there must [~~shall~~] be no unpaid, uncontested premium;[~~,~~] assessment;[~~,~~] or charge due from the applicant;[~~.~~]

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

[~~(B) For the purpose of this section, a rejection shall have occurred if the applicant is accepted in the admitted voluntary market at a rate higher than those rates approved by the commissioner from time to time under this plan.~~]

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

(A) cause a binder or [~~policy of~~] 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 [~~shall~~] 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 [~~a policy of~~] insurance policy except for:

(A) nonpayment of premium; [~~or~~]

(B) nonpayment of the applicable stabilization reserve fund charge; [~~or~~]

(C) nonpayment of assessment; [~~or~~]

(D) evidence of fraud or material misrepresentation; or

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

(F) any cause arising after [~~subsequent to~~] the policy is issued that [~~issuance of the policy which~~] would have been grounds for nonacceptance of the risk under this subchapter had the [~~such~~] cause existed at the time of acceptance; or

(G) noncompliance with reasonable loss control or risk management recommendations under [~~in accordance with~~] subsection (b)(4)(A)(vii) of this section. On [~~Upon~~] cancellation of an [~~a policy of~~] insurance policy by the association, the association must [~~shall~~] refund to the insured the unearned portion of any paid premium and, if canceled [~~cancelled~~] within the 90th day of coverage, the unearned portion of the paid fund charges under Insurance Code Chapter 2203, Subchapter G [~~§4A fund or §4B fund charge~~] on a pro rata basis provided that all assessments and fund charges earned under Insurance Code Chapter 2203, Subchapter G [~~§4A fund or §4B fund charges earned~~] 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 [~~§4A fund or §4B fund charge~~] will be refunded. Policyholder assessments and fund charges under Insurance Code Chapter 2203, Subchapter G [~~§4A fund or §4B fund charges~~] are fully earned on [~~upon~~] payment; therefore, except as provided in Insurance Code Chapter 2203 [~~the Act,~~] 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 [~~A policy of~~] insurance policy may be canceled [~~cancelled~~] at any time:

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

(B) by an insurance premium finance company in accordance with [~~the provisions contained in the~~] Insurance Code Chapter 651 [~~Article 24.17~~].

(3) Refund of unearned portion of paid premium. The association must [~~shall~~] refund the unearned portion of any paid premium[~~,~~] and, if canceled [~~cancelled~~] within the 90th day of coverage, the unearned portion of the paid fund charges under Insurance Code Chapter 2203, Subchapter G [~~§4A fund or §4B fund charge~~] according to the approved short-rate [~~short rate~~] table, provided all assessments and fund charges under Insurance Code Chapter 2203, Subchapter G [~~§4A fund or §4B fund charges~~] 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 [~~§4A fund or §4B fund charge~~] will be refunded. Policyholder assessments and fund charges under Insurance Code Chapter 2203, Subchapter G [~~§4A fund or §4B fund charges~~] are fully earned on [~~upon~~] payment; therefore, except as provided in Insurance Code Chapter 2203 [~~the Act,~~] or §5.2003(c)(2) of this title, no portion is refundable.

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

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

(A) The association may cancel a [~~policy of~~] medical liability insurance policy and general liability insurance policy, or decline to renew a [~~such~~] 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 [~~policy of~~] medical liability insurance policy and general liability insurance policy or decline to renew a [~~such~~] policy for nonpayment of premium, assessments, or fund charges under Insurance Code Chapter 2203, Subchapter G [~~§4A fund or §4B fund~~

~~charges~~], 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 [~~pursuant to~~] subparagraphs (A) and (B) of this paragraph must [~~shall~~] contain a statement of the reason for the [~~such~~] cancellation or nonrenewal and a statement that the insured has the right to appeal under Insurance Code Chapter 2203, Subchapter I [~~pursuant to the Act, §7~~].

(D) The association must [~~shall~~] 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 [~~shall~~] state the amount of the increase.

(6) General liability insurance. A [~~policy of~~] general liability insurance policy issued by the association under Insurance Code §2203.151(b) [~~pursuant to the Act, §3(d) shall~~] automatically terminates [~~terminate~~] on the same effective date and time as the termination of the medical liability insurance policy.

(d) Suspension of policy. The association must, on [~~shall, upon~~] 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 [~~the~~] Insurance Code Chapter 2212 [~~Article 21.49-4~~], at any time, on [~~upon~~] written consent from the insured filed with the association, may write the risk as regular business, in which event the association must [~~shall~~] 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 [~~shall~~] be reported to the association in the manner prescribed by the board of directors.

(2) Adjustment of loss. All losses must [~~shall~~] 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.

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

Issued in Austin, Texas, on June 6, 2017.

Norma Garcia
General Counsel
Texas Department of Insurance