

INSURANCE CODE

TITLE 10. PROPERTY AND CASUALTY INSURANCE

SUBTITLE G. POOLS, GROUPS, PLANS, AND SELF-INSURANCE

CHAPTER 2203. MEDICAL LIABILITY INSURANCE JOINT UNDERWRITING

ASSOCIATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2203.001. SHORT TITLE. This chapter may be cited as the Texas Medical Liability Insurance Underwriting Association Act.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.002. DEFINITIONS. In this chapter:

(1) "Assisted living facility" means a for-profit or not-for-profit assisted living facility.

(2) "Association" means the joint underwriting association established under this chapter.

(3) "Board of directors" means the board of directors of the association.

(4) "Health care provider" means:

(A) a person, partnership, professional association, corporation, facility, or institution licensed or chartered by this state to provide health care, as defined in Section 74.001(a)(10), Civil Practice and Remedies Code, as:

(i) a registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist;

(ii) a hospital;

(iii) a nursing home;

(iv) a radiation therapy center that is independent of any other medical treatment facility, is licensed by the Department of State Health Services in that agency's capacity as the Texas Radiation Control Agency under Chapter 401, Health and Safety Code, and is in compliance with the regulations adopted under that chapter;

(v) a blood bank that is a nonprofit

corporation chartered to operate a blood bank and is accredited by the American Association of Blood Banks;

(vi) a nonprofit corporation that is organized for the delivery of health care to the public and is certified under Chapter 162, Occupations Code;

(vii) a health center, as defined by 42 U.S.C. Section 254b, as amended; or

(viii) an assisted living facility; or

(B) an officer, employee, or agent of an entity listed in Paragraph (A) acting in the course and scope of that person's office, employment, or agency.

(5) "Medical liability insurance" means primary and excess liability insurance coverage against:

(A) the legal liability of the insured; and

(B) loss, damage, or expense incident to a claim arising out of the death or injury of a person as the result of negligence in rendering or failing to render professional service by a health care provider or physician who is in a category eligible for coverage by the association.

(6) "Net direct premiums" means gross direct premiums written on automobile liability and other liability insurance written under this code, less:

(A) policyholder dividends;

(B) return premiums for the unused or unabsorbed portion of premium deposits; and

(C) return premiums on canceled contracts written on the liability risks.

(7) "Nursing home" means a for-profit or not-for-profit nursing home.

(8) "Physician" means a person licensed to practice medicine in this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.003. IMMUNITY. Liability does not exist on the part of, and a cause of action does not arise against, the association, an association agent or employee, an insurer, an agent

licensed under this code, the commissioner or department, or an authorized representative of the commissioner or department for a statement made in good faith by any of them:

(1) in a report or communication concerning risks insured or to be insured through the association; or

(2) at an administrative hearing conducted in connection with the report or communication.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.004. APPLICABILITY OF OTHER LAW. The association is subject to Sections 401.051, 401.052, 401.054-401.062, 401.151, 401.152, 401.155, and 401.156 and Subchapter A, Chapter 86.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.005. RELATIONSHIP TO SURPLUS LINES INSURANCE. The association is not an authorized insurer for purposes of Chapter 981 with respect to medical liability insurance for physicians.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER B. ASSOCIATION ADMINISTRATION AND OPERATION

Sec. 2203.051. PURPOSE OF ASSOCIATION. The association provides medical liability insurance on a self-supporting basis.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.052. BOARD OF DIRECTORS. (a) The association is governed by a board of directors composed of the following nine members:

(1) five representatives of insurers that are required to be association members, elected by association members;

(2) one physician, appointed by the Texas Medical Association or a successor to that association;

(3) one representative of hospitals, appointed by the Texas Hospital Association or a successor to that association; and

(4) two public members, appointed by the commissioner.

(b) The board members serve one-year terms beginning on October 1 of each year.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.053. PLAN OF OPERATION. (a) The association operates under a plan of operation adopted by the commissioner.

(b) The plan of operation must:

(1) provide for economic, fair, and nondiscriminatory administration;

(2) provide for the prompt and efficient provision of medical liability insurance; and

(3) contain other provisions, including provisions relating to:

(A) the establishment of necessary facilities;

(B) the association's management;

(C) the assessment of members and policyholders to defray losses and expenses;

(D) the administration of the policyholder's stabilization reserve funds;

(E) commission arrangements;

(F) reasonable and objective underwriting standards;

(G) the acceptance, assumption, and cession of reinsurance;

(H) the appointment of servicing insurers; and

(I) procedures for determining amounts of insurance to be provided by the association.

(c) The plan of operation must direct that any revenue exceeding expenditures that remains in the association's funds at the close of the association's fiscal year, after the association reimburses members' contributions in accordance with Section 2203.255(a), be added to the association's reserves.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff.

April 1, 2007.

Sec. 2203.054. AMENDMENTS TO PLAN OF OPERATION. Amendments to the plan of operation:

(1) shall be made at the commissioner's direction; or

(2) may be made by the board of directors, subject to the commissioner's approval.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.055. JOINT UNDERWRITING ASSOCIATION MEMBERSHIP.

(a) The association is composed of each insurer, including a Lloyd's plan and a reciprocal or interinsurance exchange, authorized to write and writing liability insurance, including automobile liability insurance, on a direct basis in this state, other than:

(1) a farm mutual insurance company authorized under Chapter 911; and

(2) a county mutual insurance company authorized under Chapter 912.

(b) An insurer that is a member of the association must remain a member as a condition of the insurer's authority to engage in the business of the insurance described by Subsection (a).

(c) Each association member participates in the writings, expenses, and losses of the association in the proportion that the net direct premiums of the member, excluding the portion of premiums attributable to the operation of the association, written during the preceding calendar year bears to the aggregate net direct premiums written in this state by all association members.

(d) The association shall annually determine a member's participation in the association on the basis of the net direct premiums written by the member during the preceding calendar year, as reported in the annual statements and other reports the member files as required by the department.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.056. ANNUAL STATEMENT; ADDITIONAL INFORMATION.

(a) Not later than March 1 of each year, the association shall file with the department a statement that contains information regarding the association's transactions, condition, operations, and affairs during the preceding calendar year.

(b) The statement must:

(1) contain the matters and information required by the department; and

(2) be in the form approved by the department.

(c) The department at any time may require the association to provide additional information regarding the association's transactions or condition, or any related matter considered to be:

(1) material; and

(2) of assistance in evaluating the scope, operation, and experience of the association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER C. ELIGIBILITY FOR COVERAGE

Sec. 2203.101. GENERAL ELIGIBILITY. (a) The commissioner shall by order establish the categories of physicians and health care providers that are eligible to obtain insurance coverage from the association. The commissioner may revise the order to:

(1) include as eligible for that coverage other categories of physicians and health care providers; or

(2) exclude from eligibility for that coverage particular categories of physicians and health care providers.

(b) If a category of physicians or health care providers is excluded from eligibility to obtain insurance coverage from the association, the commissioner may determine, after notice of at least 10 days and a hearing, that medical liability insurance is not otherwise available. On that determination, the previously excluded category is eligible to obtain insurance coverage from the association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.102. INSURER OF LAST RESORT FOR CERTAIN NURSING HOMES AND ASSISTED LIVING FACILITIES. (a) A nursing home or assisted living facility not otherwise eligible for insurance coverage from the association under Section 2203.101 is eligible for that coverage if the home or facility demonstrates, in accordance with the requirements of the association, that the home or facility:

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

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

(b) In consultation with the Department of Aging and Disability Services, the commissioner by rule shall adopt minimum rating standards for for-profit nursing homes and for-profit assisted living facilities that must be met before a for-profit nursing home or for-profit assisted living facility may obtain insurance coverage through the association. The standards must promote the highest practical level of care for residents of the nursing homes and assisted living facilities.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.1021. VOLUNTEER HEALTH CARE PROVIDERS. (a) In this section:

(1) "Charitable organization" has the meaning assigned by Section 84.003, Civil Practice and Remedies Code.

(2) "Volunteer health care provider" has the meaning assigned by Section 84.003, Civil Practice and Remedies Code.

(b) The association shall make available medical liability insurance or appropriate health care liability insurance covering a volunteer health care provider for the legal liability of the person against any loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence in rendering or the failure to render professional service while acting in the course and scope of the person's duties

as a volunteer health care provider as described by Chapter 84, Civil Practice and Remedies Code.

(c) A volunteer health care provider who is serving as a direct service volunteer of a charitable organization is eligible to obtain from the association the liability insurance made available under this section. A volunteer health care provider who obtains coverage under this section is subject to Section 2203.302 and the other provisions of this chapter in the same manner as physicians who are eligible to obtain medical liability insurance from the association.

(d) This section does not affect the liability of a volunteer health care provider who is serving as a direct service volunteer of a charitable organization. Section 84.004(c), Civil Practice and Remedies Code, applies to the volunteer health care provider without regard to whether the volunteer health care provider obtains liability insurance under this section.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.060(a), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.060(a), eff. September 1, 2007.

Sec. 2203.103. ELIGIBILITY OF OTHER HEALTH CARE PRACTITIONERS AND FACILITIES. (a) In this section:

(1) "Health care" includes a medical or health care service, including an examination, treatment, medical diagnosis, or evaluation, and care provided in an inpatient, outpatient, or residential setting.

(2) "Health care facility" means a facility providing health care, other than a facility described by Section 2203.002(4).

(3) "Health care practitioner" means an individual, other than an individual described by Section 2203.002(4), who:

(A) is licensed to provide health care; or

(B) is not licensed to provide health care but provides health care under the direction or supervision of a licensed individual.

(b) After notice and opportunity for hearing, the

commissioner may:

(1) determine that appropriate liability insurance coverage written by insurers authorized to engage in business in this state is not reasonably available to a type of health care practitioner or health care facility; and

(2) by order designate that type of health care practitioner or health care facility to be included as a health care provider eligible to receive coverage under this chapter.

(c) A health care practitioner or facility designated under Subsection (b) is entitled to receive insurance coverage under this chapter in accordance with Chapter 1901 in the same manner as other health care providers described by Section 2203.002 and Section 1901.001.

(d) The commissioner's order may indicate whether a health care practitioner or facility designated under Subsection (b) is included under the policyholder's stabilization reserve fund established under Section 2203.301 or 2203.303 or whether a separate policyholder's stabilization reserve fund is created. A separate policyholder's stabilization reserve fund established under this subsection operates in the same manner as a policyholder's stabilization reserve fund created under Section 2203.303.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.104. APPLICATION FOR COVERAGE. (a) A health care provider or physician included in a category eligible for insurance coverage by the association is entitled to apply to the association for the coverage. An agent authorized under Chapter 4051 may apply on behalf of an applicant.

(b) The association shall issue a medical liability insurance policy to an applicant:

(1) if the association determines that:

(A) the applicant meets the underwriting standards of the association prescribed by the plan of operation; and

(B) there is no unpaid and uncontested premium,

policyholder's stabilization reserve fund charge, or assessment due from the applicant for prior insurance, as shown by the insured's failure to pay or to object in writing to the charges on or before the 30th day after the date of the billing; and

(2) on receipt of the premium and the policyholder's stabilization reserve fund charge, or the portion of the premium and charge prescribed by the plan of operation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER D. ASSOCIATION COVERAGE

Sec. 2203.151. POWERS RELATING TO MEDICAL LIABILITY INSURANCE COVERAGE. (a) Under this chapter and the plan of operation, the association, on behalf of the association members, may:

(1) issue, or cause to be issued, medical liability insurance policies to applicants, including primary, excess, and incidental coverages, subject to the limits specified in the plan of operation and Section 2203.152;

(2) underwrite medical liability insurance and adjust and pay losses related to that insurance, or appoint servicing insurers to perform those functions;

(3) either or both accept and refuse the assumption of reinsurance from association members; and

(4) cede and purchase reinsurance.

(b) The association may provide general liability insurance coverage to be issued in connection with medical liability insurance issued by the association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.152. POLICY LIMITS. The association may not issue one or more policies insuring an individual or organization for an amount exceeding \$1 million for each occurrence and \$3 million in the aggregate for a year.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff.

April 1, 2007.

Sec. 2203.153. FOLLOWING FORM EXCESS LIABILITY COVERAGE. Excess liability insurance coverage written for a physician or health care provider by the association under this chapter must be written as following form excess liability insurance to the physician's or provider's primary insurance coverage.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.154. PUNITIVE DAMAGES EXCLUDED. The association may not issue or renew a medical liability insurance policy for a physician or health care provider under this chapter that includes coverage for punitive damages assessed against the physician or health care provider.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.155. INSTALLMENT PLAN. The association may offer an installment payment plan for insurance coverage obtained through the association.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.156. TERM OF POLICY; NOTICE OF CERTAIN CHANGES. (a) A policy issued by the association must be for a term of one year or less, as determined by the association.

(b) Section 1901.253 does not apply to a medical liability insurance policy issued by the association for a term of less than one year.

(c) The association shall ensure that appropriate written notice is provided to the insured for a policy described by Subsection (b) if the association intends to:

- (1) increase the premiums on the policy; or
- (2) cancel or not renew the policy for a reason other than for nonpayment of premiums or because the insured is no longer licensed.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER E. RATES AND POLICY FORMS

Sec. 2203.201. APPLICABILITY OF OTHER LAW TO RATES AND POLICY FORMS. (a) Except as provided by Subsection (b) and subject to Section 2203.203, the following laws govern the rates, rating plans, rating rules, rating classifications, territories, and policy forms applicable to the insurance written by the association and related statistics:

- (1) Section 36.002(1);
- (2) Subchapter B, Chapter 5;
- (3) Subchapters A and C, Chapter 1806;
- (4) Subchapter A, Chapter 2301;
- (5) Chapter 251, as that chapter relates to casualty insurance and fidelity, guaranty, and surety bond insurance;
- (6) Chapter 253;
- (7) Chapters 2251 and 2252; and
- (8) Subtitle B.

(b) If a provision of a law described by Subsections (a)(1)-(8) conflicts with a provision of this chapter, this chapter prevails.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.202. RATE STANDARDS. (a) In determining rates, rating plans, rating rules, rating classifications, territories, and policy forms, the association shall consider:

- (1) the past and prospective loss and expense experience for medical professional liability insurance, inside and outside this state, of all of the association members;
- (2) trends in the frequency and severity of losses;
- (3) the association's investment income; and
- (4) other information the commissioner may require.

(b) Rates, rating plans, and rating rules must be based on:

- (1) the association's loss and expense experience; and

(2) other information based on that experience the department considers appropriate.

(c) The resultant premium rates must be:

- (1) actuarially sound; and
- (2) computed to be self-supporting.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.203. DISCOUNT FOR CERTAIN HEALTH CARE PROVIDERS.

(a) The rates applicable to professional liability insurance coverage provided by the association for not-for-profit nursing homes and not-for-profit assisted living facilities must reflect a discount of 30 percent from the rates for the same coverage provided to others in the same category of insureds.

(b) The commissioner shall ensure compliance with this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER F. FINANCIAL PARTICIPATION BY MEMBERS AND POLICYHOLDERS

Sec. 2203.251. DEFICIT RECOUPMENT. (a) This section applies to a deficit sustained in a single year by the association with respect to:

- (1) physicians and health care providers, other than nursing homes and assisted living facilities; or
- (2) a nursing home or assisted living facility.

(b) The deficit must be recouped in accordance with the plan of operation and the rating plan in effect when the deficit is sustained under one or more of the following procedures, in this sequence:

- (1) a contribution from the policyholder's stabilization reserve fund established under Section 2203.301 or the policyholder's stabilization reserve fund established under Section 2203.303, as appropriate, until the respective fund is exhausted;
- (2) an assessment on the policyholders in accordance

with Section 2203.252; or

(3) an assessment on the members in accordance with Sections 2203.055(c) and (d) and 2203.253.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.252. ASSESSMENT OF POLICYHOLDERS FOR DEFICIT RECOUPMENT. (a) Each policyholder within the group of physicians and health care providers, other than nursing homes and assisted living facilities, or within the group of nursing homes and assisted living facilities, has contingent liability for a proportionate share of an assessment made under this chapter of policyholders in the applicable group.

(b) If a deficit, as computed under the plan of operation, is sustained with respect to a group described by Subsection (a) in a single year, the board of directors shall levy an assessment only on the policyholders in the applicable group who held policies in force at any time during the two most recently completed calendar years:

(1) before the date the assessment is levied; and

(2) in which the association was issuing policies.

(c) The aggregate amount of an assessment under Subsection (b) must be equal to the amount of the deficit not recouped under Section 2203.251(b)(1) from the applicable policyholder's stabilization reserve fund. Subject to Subsection (d), each policyholder in the applicable group shall be assessed for a portion of the deficit that reflects the proportion that the earned premium on the policies of that policyholder bears to the total earned premium for all policies of the association in the applicable group in the two most recently completed calendar years.

(d) The maximum aggregate assessment on each policyholder in the applicable group may not exceed the annual premium for the liability insurance policy most recently in effect.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.253. LIMITATION ON REIMBURSEMENT BY MEMBER FOR

DEFICIT RECOUPMENT. (a) An association member is not obligated in a single year to reimburse the association for the member's proportionate share of the deficits from the association's operations in that year in an amount that exceeds one percent of the member's policyholder surplus. The aggregate amount not reimbursed in accordance with this subsection shall be reallocated among the other association members. The association shall reallocate that amount in accordance with the method of determining a member's participation under Sections 2203.055(c) and (d), after excluding the total net direct premiums of all members not sharing in the excess deficits.

(b) If the deficits from the association's operations allocated to all association members in a calendar year exceed one percent of all members' respective policyholder surplus, the association shall allocate to each member the amount of the deficits in accordance with the method of determining a member's participation under Sections 2203.055(c) and (d).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.254. CONTRIBUTION BY MEMBERS FOR SOUND FINANCIAL OPERATION. If sufficient funds are not available for the sound financial operation of the association, each association member shall contribute to the financial requirements of the association in accordance with Sections 2203.055(c) and (d), 2203.252, and 2203.253, as authorized and considered necessary by the department. A contribution under this section is in addition to:

(1) an assessment paid in accordance with the plan of operation under Section 2203.053(b); and

(2) a contribution from a policyholder's stabilization reserve fund.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.255. REIMBURSEMENT OF ASSESSMENT OR CONTRIBUTION; PREMIUM TAX CREDIT. (a) Subject to commissioner approval, the association shall reimburse an assessment or contribution, with

interest at a rate approved by the commissioner, to:

- (1) the association members; or
- (2) the state, to the extent that the members have recouped their assessments using premium tax credits as provided by Subsection (c).

(b) Pending recoupment or reimbursement of an assessment or contribution paid by a member to the association, the unrepaid balance of the assessment or contribution may be reflected in the member's books and records as an admitted asset of the member for all purposes, including exhibition in an annual statement under Section 862.001.

(c) To the extent a member has paid one or more assessments and has not received reimbursement from the association in accordance with Subsection (a), a credit against premium taxes under Chapter 221 is allowed at a rate of 20 percent a year for five successive years following the year in which the deficit was sustained. At the member's option, the tax credit may be taken over an additional number of years.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.256. STANDARDS FOR RECOUPMENT PROVISIONS. A provision for recoupment must be based on:

- (1) the association's loss and expense experience; and
- (2) other information based on that experience the department considers appropriate.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER G. POLICYHOLDER'S STABILIZATION RESERVE FUNDS

Sec. 2203.301. POLICYHOLDER'S STABILIZATION RESERVE FUND FOR PHYSICIANS AND CERTAIN HEALTH CARE PROVIDERS. (a) The policyholder's stabilization reserve fund for physicians and health care providers other than nursing homes and assisted living facilities is collected and administered by the association as provided by this section, Section 2203.302, and the plan of

operation.

(b) The policyholder's stabilization reserve fund shall be:

(1) credited with all policyholder's stabilization reserve fund charges collected under Section [2203.302](#);

(2) charged with any deficit sustained by physicians and health care providers, other than nursing homes and assisted living facilities, from the association's operation during the previous year;

(3) treated as a liability of the association along with, and in the same manner as, premium and loss reserves; and

(4) valued annually by the board of directors as of the close of the preceding year.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

Sec. 2203.302. POLICYHOLDER'S STABILIZATION RESERVE FUND CHARGE FOR PHYSICIANS AND CERTAIN HEALTH CARE PROVIDERS. (a) Each policyholder other than a nursing home or assisted living facility shall pay annually into the policyholder's stabilization reserve fund under Section [2203.301](#) a charge that:

(1) is in an amount established annually by advisory directors chosen by physicians and health care providers, other than nursing homes and assisted living facilities, eligible for insurance through the association in accordance with the plan of operation;

(2) is in proportion to each premium payment due for liability insurance through the association; and

(3) is separately stated in the policy.

(b) A charge stated in a policy as required by Subsection (a)(3) is not:

(1) a part of premiums; or

(2) subject to premium taxation or a servicing fee, acquisition cost, or any other similar charge.

(c) If the association offers an installment payment plan for coverage obtained through the association, the association may:

(1) permit payment of the policyholder's stabilization reserve fund charge under this section on an installment basis; or

(2) require the policyholder to pay the charge as an annual lump sum.

(d) Collections of the policyholder's stabilization reserve fund charge under this section shall continue until the net balance of the policyholder's stabilization reserve fund under Section 2203.301 is not less than the projected sum of premiums for physicians and health care providers, other than nursing homes and assisted living facilities, to be written in the year following the valuation date.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.303. POLICYHOLDER'S STABILIZATION RESERVE FUND FOR NURSING HOMES AND ASSISTED LIVING FACILITIES. (a) The policyholder's stabilization reserve fund for nursing homes and assisted living facilities is collected and administered by the association as provided by this section, Section 2203.304, and the plan of operation.

(b) The policyholder's stabilization reserve fund shall be:

(1) credited with:

(A) all policyholder's stabilization reserve fund charges collected under Section 2203.304; and

(B) the net earnings on liability insurance policies issued to nursing homes and assisted living facilities;

(2) charged with any deficit sustained by nursing homes and assisted living facilities from the association's operation during the previous year;

(3) treated as a liability of the association along with, and in the same manner as, premium and loss reserves; and

(4) valued annually by the board of directors as of the close of the preceding year.

(c) The policyholder's stabilization reserve fund under this section, and any earnings of the fund, are state funds and shall be held by the comptroller outside the state treasury on behalf of, and with legal title in, the department. No part of the fund or the earnings of the fund may inure to the benefit of an association member, a policyholder, or another individual. The

fund assets may be used in accordance with the association's plan of operation only to implement this chapter and for the purposes of the association, including to make payment to satisfy, wholly or partly, the liability of the association regarding a claim made on a policy written by the association.

(d) Notwithstanding Sections 11, 12, and 13, Article 21.49-3, the policyholder's stabilization reserve fund under this section may be terminated only by law.

(e) Notwithstanding Section 11, Article 21.49-3, on termination of the policyholder's stabilization reserve fund under this section, all assets of the fund shall be transferred to the general revenue fund to be appropriated for purposes related to ensuring the provision of the kinds of liability insurance coverage that the association may provide under this chapter to nursing homes and assisted living facilities.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.304. POLICYHOLDER'S STABILIZATION RESERVE FUND CHARGE FOR NURSING HOMES AND ASSISTED LIVING FACILITIES. (a) Each policyholder that is a nursing home or assisted living facility shall pay annually into the policyholder's stabilization reserve fund under Section 2203.303 a charge that:

(1) is in an amount established annually by advisory directors chosen by nursing homes and assisted living facilities eligible for insurance through the association in accordance with the plan of operation;

(2) is in proportion to each premium payment due for liability insurance through the association; and

(3) is separately stated in the policy.

(b) A charge stated in a policy as required by Subsection (a)(3) is not:

(1) a part of premiums; or

(2) subject to premium taxation or a servicing fee, acquisition cost, or any other similar charge.

(c) If the association offers an installment payment plan for coverage obtained through the association, the association may:

(1) permit payment of the policyholder's stabilization reserve fund charge under this section on an installment basis; or

(2) require the policyholder to pay the charge as an annual lump sum.

(d) Collections of the policyholder's stabilization reserve fund charge under this section shall continue only until the net balance of the policyholder's stabilization reserve fund under Section 2203.303 is not less than the projected sum of premiums for nursing homes and assisted living facilities to be written in the year following the valuation date.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.305. SEPARATE FUNDS. The policyholder's stabilization reserve fund for physicians and health care providers other than nursing homes and assisted living facilities described by Section 2203.301 is separate from the policyholder's stabilization reserve fund for nursing homes and assisted living facilities described by Section 2203.303.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

SUBCHAPTER H. REVENUE BOND PROGRAM

Sec. 2203.351. PURPOSE. The legislature finds that the issuance of bonds to provide a method to raise funds to provide professional liability insurance for nursing homes and assisted living facilities in this state through the association is to benefit the public and to further a public purpose.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.352. DEFINITIONS. In this subchapter:

(1) "Board" means the board of directors of the Texas Public Finance Authority.

(2) "Bond resolution" means the resolution or order authorizing bonds to be issued under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.353. APPLICABILITY OF OTHER LAWS. The following laws apply to bonds issued under this subchapter to the extent consistent with this subchapter:

(1) Chapters 1201, 1202, 1204, 1205, 1231, 1232, and 1371, Government Code; and

(2) Subchapter A, Chapter 1206, Government Code.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.354. ISSUANCE OF BONDS AUTHORIZED. On behalf of the association and subject to Section 2203.355, the Texas Public Finance Authority shall issue revenue bonds to:

(1) fund the policyholder's stabilization reserve fund for nursing homes and assisted living facilities under Section 2203.303;

(2) pay costs related to issuing the bonds; and

(3) pay other costs related to the bonds as determined by the board.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.355. LIMITATION ON AMOUNT OF BONDS. The Texas Public Finance Authority may issue on behalf of the association bonds in a total amount not to exceed \$75 million.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.356. TERMS OF ISSUANCE. (a) Bonds issued under this subchapter may be issued at a public or private sale.

(b) Bonds must:

(1) be issued in the name of the association; and

(2) mature not more than 10 years after the date issued.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff.

April 1, 2007.

Sec. 2203.357. CONTENTS OF BOND RESOLUTION; ADMINISTRATION OF ACCOUNTS. (a) In a bond resolution, the board may:

(1) provide for the flow of funds and the establishment, maintenance, and investment of funds and special accounts with regard to the bonds, including an interest and sinking fund account, a reserve account, and other accounts; and

(2) make additional covenants with regard to the bonds and the designated income and receipts of the association pledged to the payment of the bonds.

(b) The association shall administer the accounts in accordance with this chapter.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.358. SOURCE OF PAYMENT. (a) Bonds issued under this subchapter are payable only from:

(1) the surcharge fee established under Section 2203.359; or

(2) other sources the association is authorized to levy and charge and from which the association is authorized to collect in connection with paying any portion of the bonds.

(b) The bonds are obligations solely of the association and do not create a pledge, gift, or loan of the faith, credit, or taxing authority of this state.

(c) Each bond must:

(1) include a statement that the state is not obligated to pay any amount on the bond and that the faith, credit, and taxing authority of this state are not pledged, given, or loaned to those payments; and

(2) state on the bond's face that the bond:

(A) is payable solely from the revenue pledged for that purpose; and

(B) is not a legal or moral obligation of the state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff.

April 1, 2007.

Sec. 2203.359. SURCHARGE FEE. (a) A surcharge fee is assessed against:

- (1) each association member; and
- (2) the association.

(b) The commissioner shall set the surcharge fee in an amount sufficient to pay all debt service on the bonds issued under this subchapter. Each association member and the association shall pay the surcharge fee as required by the commissioner by rule.

(c) The comptroller shall collect the surcharge fee and the department shall reimburse the comptroller in the manner described by Section 201.052.

(d) The commissioner, in consultation with the comptroller, may coordinate payment and collection of the surcharge fee with other payments made by association members and collected by the comptroller.

(e) Except as provided by Subsection (f), as a condition of engaging in the business of insurance in this state, an association member agrees that, if the member leaves the liability insurance market in this state, the member remains obligated to pay the member's share of the surcharge fee assessed under this section until the bonds are retired. The amount assessed against a member under this subsection must be:

- (1) proportionate to the member's share of the liability insurance market, including automobile liability insurance, in this state as of the last complete reporting period before the date the member ceases to engage in the liability insurance business in this state; and

- (2) based on the member's gross premiums for liability insurance, including automobile liability insurance, for the member's last reporting period.

(f) An association member is not required to pay the proportionate amount under Subsection (e) in any year in which the surcharge fee assessed against association members continuing to write liability insurance in this state is sufficient to service the bond obligation.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.360. EXEMPTION FROM TAXATION. Bonds issued under this subchapter, any interest from the bonds, and all assets pledged to secure the payment of the bonds are exempt from taxation by the state or a political subdivision of this state.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.361. AUTHORIZED INVESTMENTS. Bonds issued under this subchapter are authorized investments under Subchapter B, Chapter 424, and Subchapter D, Chapter 425.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.362. STATE PLEDGE REGARDING BOND OWNER RIGHTS AND REMEDIES. (a) The state pledges to and agrees with the owners of bonds issued in accordance with this subchapter that the state will not limit or alter the rights vested in the association to fulfill the terms of agreements made with the owners or impair the rights and remedies of the owners until the following obligations are fully discharged:

- (1) the bonds;
- (2) any bond premium;
- (3) interest; and
- (4) all costs and expenses related to an action or proceeding by or on behalf of the owners.

(b) The association may include the state's pledge and agreement under Subsection (a) in an agreement with the owners of the bonds.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 2, eff. April 1, 2007.

Sec. 2203.363. PAYMENT ENFORCEABLE BY MANDAMUS. A writ of mandamus and any other legal or equitable remedy are available to a party in interest to require the association or another party to

fulfill an agreement or perform a function or duty under:

- (1) this subchapter;
- (2) the Texas Constitution; or
- (3) a bond resolution.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

SUBCHAPTER I. APPEALS

Sec. 2203.401. DEFINITION. In this subchapter, "act" includes a ruling or decision.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

Sec. 2203.402. APPEAL TO BOARD OF DIRECTORS; HEARING. (a) A person insured or applying for insurance under this chapter, the person's authorized representative, or an affected insurer that may be aggrieved by an act of the association may appeal to the board of directors not later than the 30th day after the date the act occurs. At the time the person is notified of the act, the association shall provide to the person written notice of the person's right to appeal under this subsection.

(b) The board of directors shall:

(1) hear an appeal brought under Subsection (a) not later than the 30th day after the date the board of directors receives the appeal; and

(2) give not less than 10 days' written notice of the time and place of the hearing to the person bringing the appeal or the person's authorized representative.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

Sec. 2203.403. DECISION OF BOARD OF DIRECTORS. (a) Not later than the 10th day after the date of the hearing under Section [2203.402](#)(b), the board of directors shall affirm, reverse, or modify the board's previous action or the appealed act.

(b) At the time the person is notified of the final action of

the board of directors, the association shall provide to the person written notice of the person's right to appeal under Section [2203.404](#).

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

Sec. 2203.404. APPEAL TO COMMISSIONER; HEARING. (a) Not later than the 30th day after the date of the final action of the board of directors under Section [2203.403](#), a person insured or applying for insurance aggrieved by that final action may appeal to the commissioner by making a written request for a hearing.

(b) The appeal shall be heard not later than the 30th day after the date the appeal is received. The person bringing the appeal or the person's authorized representative must be given written notice of the time and place of the hearing on or before the 10th day before the date of the hearing.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

Sec. 2203.405. COMMISSIONER'S DECISION. (a) Not later than the 30th day after the date of the hearing under Section [2203.404](#), the commissioner shall affirm, reverse, or modify the appealed act.

(b) Pending the hearing and decision, the commissioner may suspend or postpone the effective date of a rule or of the act appealed.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.

Sec. 2203.406. APPEAL OF COMMISSIONER'S DECISION. (a) The association or a person aggrieved by an order or decision of the commissioner may appeal in accordance with Subchapter D, Chapter [36](#).

(b) At the time the person is notified of the commissioner's order or decision, the commissioner shall provide to the person written notice of the person's right to appeal under this section.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. [2017](#)), Sec. 2, eff. April 1, 2007.