TITLE 22

OF THE
LOUISIANA REVISED STATUTES [1]

[As Amended Through 2005 Regular Session]

TITLE 22 – Louisiana Insurance Code

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TITLE 22. INSURANCE
LOUISIANA INSURANCE CODE

CHAPTER 1.GENERAL PROVISIONS

PART I. TITLE, DEFINITIONS, CLASSIFICATIONS, AND OTHER REGULATORY MATTERS

§1. Louisiana Insurance Code

This Title shall be known and may be cited as the "Louisiana Insurance Code".

Acts 1958, No. 125; Acts 1993, No. 664, §1; Acts 2003, No. 135, §1.

§2. Insurance regulated in the public interest

A. (1) Insurance is an industry affected with the public interest and it is the purpose of this Code to regulate that industry in all its phases. Pursuant to the authority contained in the Constitution of Louisiana, the office of the commissioner of insurance is created. It shall be the duty of the commissioner of insurance to administer the provisions of this Code. The term of office of the commissioner shall be four years and said officer shall be elected at the election for governor and other state officers.

(2) The commissioner shall appoint a chief deputy commissioner and also an assistant to the commissioner, both of whom shall serve at his pleasure and whose salaries and duties shall be fixed by him.

(3) The chief deputy commissioner shall have the authority to perform all the acts and duties of the office of the commissioner of insurance in the absence of the commissioner of insurance, in case of his inability to act, or under his direction.

B. The duties and functions relating to insurance heretofore vested in and attached to the office of the Secretary of State by authority of Section 20 of Article V of the Constitution of Louisiana and all duties and functions relative to insurance matters heretofore performed by the secretary of state are hereby transferred to the office of the Commissioner of Insurance created by this Code. No compensation shall be paid to the secretary of state in connection with insurance matters after the effective date of this Code.

C. All books, papers, records, moneys, choses in action, and any other property heretofore used or possessed by any agency or person in the exercise of the duties and functions hereby transferred shall be transferred to and become the property of the office of the commissioner of insurance created herein.

All fees, revenues, appropriations, dedicated revenues and other funds having to do with insurance matters heretofore under the authority of any agency or person in the exercise of functions hereby transferred, are hereby transferred to the office of the commissioner of insurance.

D. All employees heretofore engaged in the performance of duties, in any agency, in the exercise of functions transferred by this Code shall be transferred with such functions to the office of the commissioner of insurance and, so far as practicable, shall continue to perform the duties heretofore performed.

E. Upon the transfer of functions, any pending or unfinished business shall be taken over and completed by the commissioner of insurance, with the same power and authority as the agency from which the functions are transferred. The commissioner of insurance shall be the successor in every way to the agency from which such functions are transferred, and every act done in the exercise of such functions by the commissioner of insurance shall be deemed to have the same force and effect under any provisions of law in effect as if done by the agency from which such functions are transferred. Whenever any agency from which functions are transferred is referred to, or designated by any law or contract or other document, such reference or designations shall be deemed to apply to the commissioner of insurance. Whenever the secretary of state is referred to, or designated by any law or contract or other document, such reference or designation shall be deemed to apply to the commissioner of insurance.

F. In addition to any other authority granted by this Title, the Department of Insurance is hereby authorized to regulate the coordination of medical, surgical, and hospital benefits of a self-insurance plan with such benefits of any other insurance plan. For purposes of this Subsection, a self-insurance plan shall be defined as any plan by a person, partnership, corporation or other organization, or the state of Louisiana, other than a domestic or foreign insurance company which has qualified with the Department of Insurance, which provides or contracts to provide coverage as a self-insurer for his or its employees, stockholders, or any other persons. This Subsection shall not apply to: (1) the Office of Group Benefits, or (2) any plan of a labor organization or fraternal organization to the extent that it provides benefits to its members or the immediate family of its members, which benefits are supplemental to an employer-sponsored benefit plan.

G.(1) Notwithstanding any other provision of law to the contrary, any entity issuing or providing coverage in this state for health care services, whether the coverage is by direct payment of or reimbursement for expenses incurred for such services, or otherwise, shall be presumed to be subject to the jurisdiction of the commissioner of insurance, unless the entity shows that, while providing the coverage, it is subject to the jurisdiction of another department or agency of the state, or any political subdivision of this state, or of the federal government.

(2) An entity providing or issuing coverage for health care services in this state as described in Paragraph (1) of this Subsection may show that it is subject to the jurisdiction of another department or agency of this state, any political subdivision of this state, or the federal government by submitting to the commissioner of insurance the appropriate certificate, license, or other document or documentary evidence issued by such other governmental entity that authorizes or qualifies it to issue or provide such coverage.

(3) Proof of jurisdiction by such other governmental agency shall be submitted to the commissioner of insurance prior to the issuance or provision in this state of any coverage as described in this Subsection. The commissioner of insurance may take any action as may be authorized in this Title to enforce the provisions of this Subsection.

(4) Any entity that fails to show that it is subject to the jurisdiction of any other governmental entity as described in this Subsection shall be subject to all appropriate provisions of this Title and shall submit to an examination by the commissioner of insurance to determine its organization and solvency and whether it is in compliance with the applicable provisions of this Title.

H. In addition to any other powers granted by the Louisiana Insurance Code, the commissioner of insurance is hereby empowered to promulgate any rule or regulation necessary to meet the requirements for the accreditation of the Louisiana Department of Insurance under the National Association of Insurance Commissioners, Financial Regulation Standards and Accreditation Program. Such implementation shall be subject to the legislative oversight of the Senate and House Committees on Insurance in accordance with R.S. 49:968.

I. The commissioner shall maintain, as confidential, any document or information received from the National Association of Insurance Commissioners, insurance department of other states, international, federal, or state law enforcement agencies, and international, federal, or state regulatory agencies with statutory oversight over the financial services industry, which is confidential under the law of the state that sent the document or the applicable laws and regulations of the federal agency. The commissioner may provide documents or information, including otherwise confidential documents or information, to state, federal, or international law enforcement agencies, to the National Association of Insurance Commissioners, insurance departments of other states, or to other state, federal, or international regulatory agencies with statutory oversight over the financial services industry, including but not limited to the Louisiana Office of Financial Institutions, if the recipient agrees to maintain the confidentiality of those documents which are confidential under the laws of this state. The sharing of confidential or privileged information in accordance with this Subsection shall not be deemed a waiver of any privilege or claim of confidentiality in the documents, materials, or information.The commissioner is authorized to use such documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

Acts 1958, No. 125. Amended by Acts 1960, No. 138, §1; Acts 1965, No. 61, §6; Acts 1969, No. 11, §4; Acts 1974, No. 433, §4; Acts 1979, No. 236, §5, eff. Sept. 1, 1979; Acts 1980, No. 376, §4, eff. Sept. 1, 1980; Acts 1981, No. 636, §7, eff. Sept. 1, 1981; Acts 1982, No. 637, §1; Acts 1990, No. 641, §1; Acts 1992, No. 811, §1; Acts 1995, No. 846, §1, eff. Jan. 8, 1996; Acts 1995, No. 1203, §1, eff. June 29, 1995; Acts 1999, No. 885, §1, eff. June 30, 1999; Acts 2001, No. 1169, §1; Acts 2001, No. 1178, §2, eff. June 29, 2001; Acts 2003, No. 933, §1.

§2.1. Public records; forms and methods; electronic signatures and filings; timely filing of papers

A. Notwithstanding any other provision of law to the contrary, any public record maintained by the commissioner of insurance may be kept in any written, photographic, microfilm, or other similar form or method, or may be kept by any magnetic, electronic, optical, or similar form of data compilation which is approved for such use in a rule promulgated by the commissioner. No such magnetic, electronic, optical, or similar form of data compilation shall be approved unless it provides reasonable safeguards against erasure or alteration.

B. The commissioner may, at his discretion, cause any public record maintained by him or any part thereof to be microfilmed, or otherwise reproduced, in order to accomplish efficient storage and preservation of such records.

C. A certified copy of a public record maintained by the commissioner shall be deemed to be an original for all purposes and shall be admissible in evidence in all courts or administrative agencies as if it were the original.

D. Subject to such guidelines and limitations as may be promulgated by the commissioner, electronic signatures are hereby authorized.

E. The commissioner shall promulgate rules to regulate the use of electronic signatures. Such rules may include limitations upon which documents may be signed electronically.

F. The commissioner may permit or require rate, form or any other filings, along with any accompanying supplementary rate information or supporting information, to be filed electronically.

G. If the commissioner permits or requires electronic filings pursuant to Subsection F of this Section, the commissioner shall arrange for payment of filing fees by electronic funds transfer.

H. The time for acting on filings made electronically shall be the same as the time for acting on filings made in writing. Filings made electronically shall be considered received by the commissioner when received in the electronic data processing system used by the commissioner to review filings, unless received on a weekend or legal holiday, in which case filings are deemed received on the next business day. Communications from the commissioner to persons making filings electronically shall be considered received by that person when the communication is sent to the person making the filing.

I. Grounds for approval, disapproval, or withdrawal of approval for filings made electronically shall be the same grounds for these actions as to filings made in writing, except that the commissioner may waive filing requirements relating to filings made in writing, such as requirements for original signatures or the number of copies, and the commissioner may disapprove or withdraw approval of a filing if it does not comply with the commissioner's requirements for electronic filings.

J. Filings made electronically shall be subject to the law of this state relating to inspection of public records pursuant to the Public Records Act, Title 44 of the Louisiana Revised Statutes of 1950, or any other applicable law.

K. The commissioner may promulgate rules and regulations which the commissioner deems necessary for the administration of electronic filings.

L. Notwithstanding any other law to the contrary, the filing of papers, including but not limited to applications, forms, reports, returns, statements, and filings of any kind with the commissioner subject to the exceptions and provisions in Subsections A through K of this Section shall not be subject to the provisions of R.S. 1:60 but shall be subject to other relevant provisions of law or rules or regulations of the commissioner.

Acts 1999, No. 1304, §1, eff. July 12, 1999; Acts 2001, No. 1032, §8.

§3. Compliance with Code required; rules and regulations by commissioner

No person shall be authorized to transact or shall transact a business of insurance in this state without complying with the provisions of this Code. The commissioner of insurance may promulgate rules and regulations that he determines are necessary for implementation of this Title. Such implementation shall be subject to the legislative oversight of the House of Representatives and Senate committees on insurance in accordance with R.S. 49:968.

Acts 1958, No. 125. Amended by Acts 1979, No. 117, §1; Acts 1992, No. 463, §1.

§4. Insurer: qualification required

No person shall act as an insurer in this state unless properly qualified as an insurer of a type permitted under the provisions of this Code.

Acts 1958, No. 125.

§5. General definitions

In this Code, unless the context otherwise requires, the following definitions shall be applicable:

(1) "Alien Insurer" is one formed under the laws of any country other than the United States.

(2) "Approved unauthorized insurer" means an insurer without a certificate of authority, or otherwise qualified under the provisions of this Code, and which is on the list of approved unauthorized insurers under the provisions of R.S. 22:1262.1, and from which a licensed surplus lines broker may procure insurance under provisions of R.S. 22:1257.

(3) "Authorized insurer" means an insurer with a certificate of authority or license issued under provisions of this Code or otherwise qualified under R.S. 22:2071 et seq.

(4) "Commissioner of Insurance" as that office is created and defined by this Code shall have full power and authority to act as insurance commissioner for the state of Louisiana and is hereby declared to be the proper officer to act for this state and to represent this state as a member of the National Association of Insurance Commissioners.

(5) "Control", as used in this Code relative to ownership, shall mean ownership representing or the authority to represent over fifty percent of the total one hundred percent ownership.

(6) "Directive" means a written communication or order issued by or on behalf of the commissioner of insurance to a person whose activities are regulated by this Title, which instructs the person to act in conformance with this Title, or any rule or regulation adopted in accordance with the Administrative Procedure Act.

(7) "Domestic Insurer" is one formed under the laws of this state.

(8) "Foreign Insurer" is one formed under the laws of any other state or territory of the United States or the District of Columbia.

(9)(a) "Insurance" is a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies. It shall include any trust, plan or agreement, popularly known as employee benefit trusts, not specifically exempted from state regulation under Public Law 93-406, except collectively bargained union welfare plans, single employer plans or plans of the state or political subdivisions.

(b) The establishment and operation of one or more professional or public liability trust funds by a statewide hospital association in this state for the purpose of providing a means by which any type of professional malpractice or public liability claims or judgments arising from such claims against hospitals which are members of the association and claims against members of societies of the association shall be paid or settled shall not be deemed to be insurance and such trust or trusts shall not be deemed to be licensed, admitted or authorized insurers but shall be subject to Parts XX, XXVI, XXVIII, and XXIX of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950. An annual audited statement for each such trust shall be filed with the commissioner of insurance. The commissioner of insurance shall also have the authority to examine the books, records and affairs of the trust funds.

(c) The establishment and operation of professional and public liability trust funds by a nonprofit beneficiary organization as set forth in Part XIII of Chapter 2 of Title 22 of the Louisiana Revised Statutes of 1950 shall not be deemed to be insurance and the trusts shall not be deemed to be a licensed, admitted, or authorized insurer but shall be subject to Parts XX, XXVI, XXVIII, and XXIX of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950. An annual audited statement shall be filed with the commissioner of insurance. The commissioner of insurance shall also have the authority to examine the books, records, and affairs of the trust fund.

(d) The establishment and operation of one or more professional, trade, and occupational or public liability trust funds by professional associations in this state for the purpose of providing a means by which professional malpractice and public liability claims or judgments arising from such claims against members of the associations shall be paid or settled shall not be deemed to be insurance, and the trust shall not be deemed to be a licensed, admitted, or authorized insurer but shall be subject to Parts XX, XXVI, XXVIII, and XXIX of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950. An annual audited statement shall be filed with the commissioner of insurance. The commissioner of insurance shall also have the authority to examine the books, records, and affairs of the trust fund.

(10) "Insurer" includes every person engaged in the business of making contracts of insurance, other than a fraternal benefit society. A reciprocal, an inter-insurance exchange, insurance exchange syndicate, or a Lloyds organization is an "insurer". Any person who provides an employee benefit trust as specified in R.S. 22:5(9)(a) is an insurer. A health maintenance organization is an insurer but only for the purposes enumerated in R.S. 22:2002(7).

(11) "Life Insurer" as used in this Code, shall mean all insurers issuing life insurance contracts, including industrial and service insurers.

(12) "Person" means any individual, company, insurer, association, organization, reciprocal or inter-insurance exchange, partnership, business, trust, or corporation.

(13) "Premium" as used in this Code means all sums charged, received, or deposited as consideration for the purchase or continuance of insurance for a definitely stated term, and shall include any assessment, membership, policy, survey, inspection, service or similar fee or charge made by an insurer as a part of the consideration for the purchase or continuance of insurance. The term premium, as used in R.S. 22:636(D) and 637(B), shall not include any assessment, membership, policy, survey, inspection, service or similar fee or charge made by an insurer as part of the consideration for the purchase or continuance of insurance.

(14) "Resident" shall mean any individual, company, insurer, partnership, association, organization, corporation, reciprocal or inter-insurance exchange, business, or trust that principally resides or maintains a principal place of business in this state.

(15) "Secretary of State" as used in this Code means the secretary of state of the state of Louisiana where that designation appears, to the extent that the functions to be performed by the secretary of state as designated therein involve the recordation of documents or his appointment as attorney to accept service of process in legal proceedings.

(16) "Small company" means a domestic life insurer which does business exclusively in the state of Louisiana, with admitted assets not exceeding ten million dollars and having gross annual premiums not exceeding two million dollars.

(17) "Surplus lines insurance" means any property and casualty insurance in this state on properties, risks, or exposures, located or to be performed in this state, permitted to be placed through a licensed surplus lines broker with an approved unauthorized insurer.

(18) "Unauthorized insurer" means an insurer which does not possess a certificate of authority to do business in the state.

Acts 1958, No. 125. Amended by Acts 1975, No. 324, §1; Acts 1978, No. 545, §1; Acts 1986, No. 375, §1; Acts 1986, No. 574, §1; Acts 1986, No. 902, §1; Acts 1989, No. 602, §1, eff. Sept. 1, 1989; Acts 1989, No. 666, §1, eff. Sept. 1, 1989; Acts 1993, No. 59, §1; Acts 1997, No. 1340, §1, eff. July 15, 1997; Acts 1999, No. 1304, §1; Acts 2002, 1st Ex. Sess., No. 87, §1, eff. June 16, 2002; Acts 2003, No. 70, §1; Acts 2004, No. 325, §1, eff. June 18, 2004.

§6. Kinds of insurance

Insurance shall be classified as follows:

(1) Life. Insurance on human lives and insurances appertaining thereto or connected therewith. For the purposes of this Code, the transacting of life insurance includes the granting of annuities or survivorship benefits; additional benefits, including the acceleration of life or endowment or annuity benefits in advance of the time they would otherwise be payable, in the event of death by accident; additional benefits in event of the total and permanent disability of the insured; and optional modes of settlement of proceeds.

(2)(a) Health and accident. Insurance of human beings against bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement, or expense resulting from sickness or old age, or against major expenses incurred by an employee benefit plan due to the illness or injury of a covered employee, or against major expenses incurred by a health care provider at financial risk for provision of health care to persons under an agreement, and every insurance appertaining thereto, including insurance wherein the benefits are covered at a higher level when health care is received from a defined network of health care providers, provided, however, that such insurance meets all applicable requirements of Part XII of Chapter 2 of this Title for provision of coverage through designated providers of medical services.

(b)(i) Limited benefit. Health and accident insurance policy designed, advertised, and marketed to supplement major medical insurance that includes accident-only, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), dental, disability income, fixed indemnity, long-term care, Medicare supplement, specified disease, vision, and any other health and accident insurance, other than basic hospital expense, basic medical-surgical expense, or other major medical insurance.

(ii) Repealed by Acts 1999, No. 294, §2.

(3) Vehicle. Insurance against loss or damage to any land vehicle or aircraft or any draft or riding animal or to property while contained therein or thereon or being loaded or unloaded therein or therefrom, and against any loss or liability resulting from or incident to ownership, maintenance, or use of any such vehicle or aircraft or animal.

Insurance against accidental death or accidental injury to individuals including the named insured while in, entering, alighting from, adjusting, repairing, cranking, or caused by being struck by a vehicle, aircraft, or draft or riding animal, if such insurance is issued as part of insurance on the vehicle, aircraft, or draft or riding animal, shall be deemed to be vehicle insurance.

(4) Liability. Insurance against the liability of the insured for the death, injury or disability of an employee or other person, and insurance against the liability of the insured for damage to or destruction of another person's property.

(5) Worker's compensation. Insurance of the obligations accepted by, imposed upon, or assumed by employers under law for worker's compensation.

(6) Burglary and Forgery. Insurance against loss or damage by burglary, theft, larceny, robbery, forgery, fraud or otherwise, including the personal property floater.

(7) Glass. Insurance against loss or damage to glass including lettering, ornamentation and fittings from any cause.

(8) Fidelity and Surety. Becoming surety or guarantor for any person, copartnership, or corporation in any position or place of trust or as custodian of money or property, public or private; or becoming a surety or guarantor for the performance of any person, copartnership or corporation of any lawful obligation, undertaking, agreement, or contract of any kind, except contracts or policies of insurance; or guaranteeing against loss or damage resulting from failure of debtors to pay their obligations to the insured; and underwriting blanket bonds, however, no insurer, except the Federal Deposit Insurance Corporation, the Federal Savings and Loan Insurance Corporation, the National Credit Union Administration or any similar insurance corporation hereinafter created by the Congress of the United States or the legislature of any state, shall insure deposits in banks, savings and loan associations, credit unions, finance operations, or similar institutions. Such obligations shall be known and treated as suretyship obligations and such business shall be known as surety business.

(9) Title. Insurance of owners of property or others having an interest therein, against loss by encumbrance, or defective titles, or adverse claim to title, and services connected therewith.

(10) Fire and extended coverage.

(a) Insurance against loss or damage by fire, smoke and smudge, lightning or other electrical disturbances;

(b) Insurance against loss or damage by earthquake, windstorms, cyclone, tornado, tempests, hail, frost, snow, ice, sleet, flood, rain, drought or other weather or climatic conditions including excess or deficiency of moisture, rising of the waters of the ocean or its tributaries;

(c) Insurance against loss or damage by bombardment, invasion, insurrection, riot, strikes, civil war or commotion, military or usurped power, or explosion (other than explosion of steam boilers and the breaking of fly wheels);

(d) Insurance authorizing the insurer to repair, rebuild or replace with new materials of like size, kind and quality, property damaged or destroyed by fire or other perils insured against.

(e) Insurance against loss or damage to property from any other hazard or cause and against loss consequential upon such loss or damage.

(11) Steam boiler and sprinkler leakage.

(a) Insurance against loss or damage to property and any liability of the insured resulting from the ownership, maintenance or use of elevators, except loss by fire or caused by the explosion of or accidents to boilers, pipes, pressure containers, machinery, and apparatus of any kind and any apparatus connected thereto, or used for creating, transmitting or applying power, light, heat, steam or refrigeration, and including the making of, inspection of and issuing certificates of inspection upon elevators, boilers, machinery and apparatus of any kind and all mechanical apparatus and appliances appertaining thereto;

(b) Insurance against loss or damage by water entering through leaks or openings in buildings, or from the breakage or leakage of a sprinkler, pumps, water pipes, plumbing and all tanks, apparatus, conduits and containers designed to bring water into buildings or for its storage or utilization therein, or caused by the falling of a tank, tank platform or supports, or against loss or damage from any cause to such sprinkler, pumps, water pipes, plumbing, tanks, apparatus, conduits, or containers.

(12) Crop and live stock.

(a) Insurance against loss or damage from insects, diseases or other causes to trees, crops or other products of the soil;

(b) Insurance against loss by death or damage to any domesticated or wild animal from disease, lightning, tornadoes, cyclones, accidents, and every other casual or accidental cause, also against theft.

(13) Marine and transportation (inland marine).

(a) Insurance against loss or damage to vessels, craft, aircraft, vehicles of every kind, (excluding vehicles operating under their own power or while in storage not incidental to transportation) as well as all goods, freights, cargoes, merchandise, effects, disbursements, profits, moneys, bullion, precious stones, securities, choses in action, evidences of debt, valuable papers, bottomry and respondentia interests and all other kinds of property and interests therein, in respect to, appertaining to or in connection with any or all risks or perils of navigation, transit or transportation, including war risks, on or under any seas or other waters, on land or in the air, or while being assembled, packed, crated, baled, compressed or similarly prepared for shipment or while awaiting the same or during any delays, storage, trans-shipment or reshipment incident thereto, including marine builder's risks and all personal property floater risks;

(b) Insurance against loss or damage to persons or property in connection with or appertaining to marine, inland marine, transit or transportation insurance, including liability for loss of or damage to either arising out of or in connection with the construction, repair, operation, maintenance, or use of the subject matter of such insurance, (but not including life insurance or surety bonds nor insurance against loss by reason of bodily injury to the person arising out of the ownership, maintenance or use of automobiles);

(c) Insurance against loss or damage to precious stones, jewels, jewelry, gold, silver, and other precious metals whether used in business or trade or otherwise and whether the same be in course of transportation or otherwise, which shall include jewelers' block insurance;

(d) Insurance against loss or damage to bridges, tunnels and other instrumentalities of transportation and communication (excluding buildings, their furniture and furnishings, fixed contents and supplies held in storage) unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and civil commotion are the only hazards to be covered; and to piers, wharves, docks and slips, excluding the risks of fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and civil commotion; and to other aids to navigation and transportation, including dry docks and marine railways, dams and appurtenant facilities for the control of waterways, against all risks;

(e) "Marine protection and indemnity insurance", meaning insurance against, or against legal liability of the insured for, loss, damage, or expense incident to ownership, operation, chartering, maintenance, use, repair, or construction of any vessel, craft, or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness, or death or for the loss of or damage to the property of another person, except this definition shall not include vessels and watercraft under five tons gross weight.

(14) Miscellaneous. Any other kind of loss, damage, or liability properly the subject of insurance and not within any other kind or kinds of insurance as defined in this Section, if such insurance is not contrary to law or public policy.

(15) Homeowners' insurance. A policy of insurance on a one- or two-family owner-occupied premises, which combines fire and allied lines with any one or more perils of casualty, liability, or other types of insurance within one policy form at a single premium, where the insurer's liability for damage to the premises under said policy is determined with reference to the replacement value of the premises.

(16)(a) Credit life, health, and accident insurance. Insurance generally sold in connection with a credit transaction and limited to partially or wholly extinguishing the credit obligation, including but not limited to agreements, contracts, or policies of insurance containing the following: credit life, credit health, and disability. It also includes accidental death and dismemberment insurance sold in connection with a credit transaction that may or may not require benefits payable to wholly or partially extinguish the credit obligation. The credit obligation is the total sum payable, including all loan finance charges and credit service charges, pursuant to the credit transaction.

(b) Credit property and casualty insurance. Insurance generally sold in connection with a credit transaction and limited to partially or wholly extinguishing the credit obligation, including but not limited to agreements, contracts, or policies of insurance containing any of the following: involuntary unemployment, vendors single interest, vendors dual interest, and credit fire, or GAP. The credit obligation is the total sum payable, including all loan finance charges and credit service charges, pursuant to the credit transaction.

(17) Annuity. A contract sold by insurance companies that pays an income benefit for the life of a person, for the lives of two or more persons, or for a specified period of time, or a contract that may provide for a series of payments to be made or received at regular intervals at the direction of the contract holder.

Acts 1958, No. 125. Amended by Acts 1969, No. 73, §1; Acts 1983, 1st Ex. Sess., No. 1, §6; Acts 1983, No. 351, §2; Acts 1991, No. 909, §1; Acts 1995, No. 593, §1; Acts 1997, No. 1340, §1, eff. July 15, 1997; Acts 1999, No. 1312, §1 Acts 2001, No. 64 §1, eff. May 24, 2001; Acts 2003, No. 132, §1; Acts 2004, No. 441, §1, eff. June 24, 2004; Acts 2005, No. 27, §1, eff. June 9, 2005.

§7. Penalty for violations

A. Whoever intentionally violates, aids, abets, counsels, or procures another person to intentionally violate any provision of this Code, upon conviction, unless a specific penalty is provided elsewhere in this Code, and in addition to any revocation, suspension, or forfeiture of any license, power, or privilege provided for in this Code, if a corporation, shall be fined not more than fifty thousand dollars; a natural person shall be fined not more than ten thousand dollars, or imprisoned with or without hard labor for not more than five years, or both.

B. The provisions of this Section shall not be applicable to a violation of any provision of Part XXV of Chapter 1 of this Code, R.S. 22:1131 et seq.

Added by Acts 1979, No. 255, §1.Acts 1992, No. 1113, §1; Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996; H.C.R. No. 4, 2002 1st Ex. Sess.

§8. Assessments on insurers; disposition of fees

A. The Department of Insurance shall be comprised of the office of the commissioner, the office of management and finance, the office of property and casualty, the office of receivership, the office of licensing and compliance, the office of financial solvency, the office of health insurance, the division of legal services, the division of public affairs, the division of minority affairs, and any other office or division that may be included by the Executive Reorganization Act or other law. Each office or division shall be administered as prescribed by Titles 36 and 39 of the Louisiana Revised Statutes of 1950.

B. The commissioner of insurance shall assess every insurer subject to the jurisdiction of the Department of Insurance, as provided by law.

C. Subject to the exceptions contained in Article VII, Section 9 of the Constitution of Louisiana, all monies, funds, proceeds, and fees except for insurance premium taxes, and dedicated funds for the Municipal Police Employee's Retirement System, Sheriff's Pension and Relief Fund, and the Firefighters' Retirement System received or collected by the commissioner under the provisions of this Title shall be deposited immediately upon receipt into the state treasury and shall be credited to the Bond Security and Redemption Fund.

Acts 1986, No. 473, §1, eff. July 1, 1986; Acts 1992, No. 984, §7; Acts 1999, No. 885, §1, eff. June 30, 1999; Acts 2001, No. 184, §1, eff. July 1, 2001.

§9. Louisiana Health Care Commission; creation

A.(1) There is hereby created the Louisiana Health Care Commission within the Department of Insurance. The commission shall be domiciled in Baton Rouge, and its members shall serve for terms of two years beginning July 1, 1999. The functions, duties, and responsibilities of the commission shall be to review and study the availability, affordability, and delivery of quality health care in the state. The commission shall specifically examine the rising costs of health care in the state, including but not limited to the cost of administrative duplication, the costs associated with excess capacity and duplication of medical services, and the costs of medical malpractice and liability and shall examine the adequacy of consumer protections, as well as the formation and implementation of insurance pools that better assure citizens the ability to obtain health insurance at affordable costs and encourage employers to obtain health care benefits for their employees by increased bargaining power and economies of scale for better coverage and benefit options at reduced costs. Further, the commission shall examine the implementation issues related to national health care reform initiatives. Of the members of the commission, three members shall be appointed from a list of nominees submitted by the governing boards of state colleges and universities and by a dean from the business schools represented by the Louisiana Association of Independent Colleges and Universities. One member of the Senate Committee on Insurance shall be appointed by the president of the Senate and one member of the House Committee on Insurance shall be appointed by the speaker of the House of Representatives to the commission to act as ex officio, nonvoting members. One member of the commission shall be appointed by the secretary of the Department of Health and Hospitals. The commissioner of insurance shall appoint five at-large members to the commission. The remainder of the members shall be appointed by the commissioner of insurance from a list of nominees, one nominee to be submitted by each of the following:

(1) The Louisiana Insurers' Conference.
(2) Louisiana Association of Health Plans.
(3) America's Health Insurance Plans.
(4) A domestic mutual, nonprofit health service and indemnity company.
(5) Louisiana State Medical Society.
(6) Louisiana Trial Lawyers' Association.
(7) Louisiana Health Care Campaign.
(8) Agenda for Children.
(9) REPEALED BY ACTS 2004, No. 495, §2.
(10) Louisiana State Program of the American Association of Retired Persons.
(11) The National Federation of Independent Businesses.
(12) Louisiana Health Care Alliance.
(13) Louisiana Independent Pharmacies Association.
(14) American Association of Retired Persons, the nominee of which shall be a volunteer representative.
(15) Louisiana Association of Business and Industry.
(16) Louisiana Health Plan.
(17) Louisiana Association of Insurance and Financial Advisors.
(18) League of Women Voters.
(19) Louisiana Hospital Association.
(20) Louisiana Primary Care Association.
(21) Louisiana Coalition for Maternal and Infant Health.
(22) A domestic commercial health insurance issuer.
(23) Chiropractic Association of Louisiana.
(24) Louisiana AFL-CIO.
(25) Louisiana Physical Therapy Association.
(26) Louisiana State Nurses Association.
(27) Louisiana Dental Association.
(28) Louisiana Nursing Home Association.
(29) Louisiana's Medicare Peer Review Organization as designated by the Health Care Financing Administration.
(30) Louisiana Business Group on Health.
(31) Louisiana Association of Health Underwriters.
(32) Louisiana Psychological Association.
(33) Optometry Association of Louisiana.
(34) National Independent Insurance Agents.
(35) National Medical Association.
(36) National Association for the Advancement of Colored People.
(37) Association of Community Organizations for Reform Now.
(38) Louisiana Council on Human Relations.

(39) National Dental Association.

B. The commissioner of insurance, or his designee, shall serve ex officio on the commission and the commissioner shall appoint a chairman and vice chairman to serve terms of two years.

C. Each appointment by the commissioner shall be confirmed by the Senate.

D. The members of the commission shall serve without compensation.

E. Vacancies in the offices of the members shall be filled in the same manner as the original appointments for the unexpired portion of the term of the office vacated.

F. A quorum for the transaction of business by the commission shall be forty percent of the membership of the commission. All official actions of the commission shall require the affirmative vote of a majority of a quorum of the commission present and voting during meetings of the commission.

G. The commission shall meet twice in any one calendar year and may meet on the call of the chairman or upon the request of any three members.

H. The commission shall serve as an advisory body to the commissioner and shall submit to the commissioner its recommendations on all matters which it is charged to examine pursuant to Paragraph A of this Section. The commission may conduct public hearings to receive testimony about the availability and affordability of health care in the state. The commission shall also be permitted to receive further information and testimony from regional and national experts on health care access issues.

I. The commissioner shall submit a yearly report on health care and health insurance, which takes into consideration the recommendations, actions, and studies of the commission, to the legislature prior to each annual regular session.

J. The commissioner may employ such persons, including experts, as necessary to carry out the provisions of this Part and may fix the compensation of technical, professional, and clerical employees as needed for the commission to complete its work. Any such employee shall be compensated from the budget of the commissioner. The commission shall employ a director and an assistant director, who shall be appointed by the commission subject to the approval of the commissioner of insurance. The director and assistant director shall be in the unclassified service. All employees of the commission shall be under the direction and supervision of the commissioner of insurance.

Acts 1992, No. 1068, §1; Acts 1993, No. 665, §1; Acts 1995, No. 594, §1; Acts 1997, No. 869, §1; Acts 1999, No. 446, §1; Acts 2001, No. 67, §1, eff. May 24, 2001; Acts 2004, No. 495, §1.

§9.1. Terminated by Acts 1995, No. 340, §2, eff. March 1, 1999.

§10. Patient's Bill of Rights

It is hereby declared by the Legislature of Louisiana that access to health care for the citizens of this state is a necessary priority and necessary to promote well-being and strong state protections. The state has an obligation to ensure that every person enrolled in a health plan enjoys basic rights as a patient. Comprehensive care should guarantee patients greater access to information and necessary care including access to needed specialists and emergency rooms, guarantee a fair appeals process when health plans deny care, expand choice, protect the doctor-patient relationship, and hold managed care organizations accountable for decisions that end up harming patients. Because many states have passed patient protection laws that are appropriate to their state, there shall be a mechanism by which the state shall review such laws and determine the practicality of implementing such measures in the Louisiana Legislature. The Department of Insurance shall establish and maintain an information collection program to track and evaluate state and federal legislation to provide for a uniform patient bill of rights. The department shall compile the data on an annual basis and submit a written report to the Senate Committee on Insurance and the House Committee on Insurance of ongoing efforts to adopt or enact a uniform patient's bill of rights.

Acts 2003, No. 68, §1.

§11. Uniform claim forms; promulgation, implementation

A. The Department of Insurance shall promulgate rules and regulations for the establishment of uniform claim forms, in both written form and by electronic means, for all hospital, health, or medical expense insurance policies, hospital or medical service contracts, employee benefit or health maintenance plans, health maintenance organizations (HMOs), health and accident policies, including the Office of Group Benefits programs, or any other insurance contract of that type for the reimbursement of services rendered.

B. The forms prescribed by the Department shall include the National Uniform Bill-82 (UB-82) or its successor for appropriate hospital services, and the current Health Care Financing Administration* (HCFA) Form 1500 or its successor for physical and other appropriate professional services. If, after consultation with insurers, providers, and consumer groups, the commissioner determines that the state assignable portions of either form should be revised, he shall make a revision request to the State Uniform Bill Implementation Committee and if approved, prescribe the use of the revised form.

C. The rules and regulations shall be promulgated in accordance with the Administrative Procedure Act and become effective no later than November 1, 1993.

*Acts 1993, No. 653, §1; Acts 2001, No. 1178, §2, eff. June 29, 2001.*Now Centers for Medicare and Medicaid Services*

§11.1 Health care provider credentialing

A. As used in this Section, the following words and phrases shall have the following meanings ascribed for each, unless the context clearly indicates otherwise:

(1) "Applicant" means a health care provider seeking to be approved or credentialed by an issuer to provide health care services to the issuer's enrollees or insureds.

(2) "Commissioner" means the commissioner of insurance.

(3) "Credentialing" or "recredentialing" means the process of assessing and validating the qualifications of health care providers applying to be approved by a health insurance issuer to provide health care services to the health insurance issuer's enrollees or insureds.

(4) "Enrollee or insured" means an individual who is enrolled or insured by a health insurance issuer for health insurance coverage.

(5) "Health care provider" or "provider" means a physician licensed to practice medicine by the Louisiana State Board of Medical Examiners or other individual health care practitioner licensed, certified, or registered to perform specified health care services consistent with state law.

(6) "Health care provider" or "provider" means a physician licensed to practice medicine by the Louisiana State Board of Medical Examiners or other health care practitioner or facility licensed, certified, or registered to perform specified health care services consistent with state law.

(7) "Health care services" or "services" means services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(8) "Standardized information" means customary universal data concerning an applicant's identity, education, and professional experience relative to an issuer's credentialing process, including but not limited to name, address, telephone number, date of birth, social security number, educational background, state licensing board number, residency program, internship, specialty, subspecialty, fellowship, or certification by a regional or national health care or medical specialty college, association or society, prior and current place of employment, an adverse medical review panel opinion, a pending professional liability lawsuit, final disposition of a professional liability settlement or judgment, and information mandated by health insurance issuer accrediting organizations.

(9) "Verification" or "verification supporting statement" means documentation confirming the information submitted by an applicant for a credentialing application from a specifically named entity or a regional, national, or general data depository providing primary source verification, including but not limited to a college, university, medical school, teaching hospital, health care facility or institution, state licensing board, federal agency or department, professional liability insurer, or the National Practitioner Data Bank.

B. (1) Any health insurance issuer that requires a health care provider to be credentialed, recredentialed, or approved by the issuer prior to rendering health care services to an enrollee or insured shall complete a credentialing process within ninety days from the date on which the issuer has received all the information needed for credentialing, including the health care provider's correctly completed application and attestations and all verifications or verification supporting statements required by the issuer to comply with accreditation requirements and generally accepted industry practices and provisions to obtain reasonable applicant-specific information relative to the particular or precise services proposed to be rendered by the applicant.

(2)(a) Within thirty days of the date of receipt of an application, a health insurance issuer shall inform the applicant of all defects and reasons known at the time by the issuer in the event a submitted application is deemed to be not correctly completed.

(b) A health insurance issuer shall inform the applicant in the event that any needed verification or a verification supporting statement has not been received within sixty days of the date of the issuer's request.

(3) In order to establish uniformity in the submission of an applicant's standardized information to each issuer for which he may seek to provide health care services, until submission of an applicant's standardized information in a hard-copy, paper format is superseded by a provider's required submission and a health insurance issuer's required acceptance by electronic submission, an applicant shall utilize and a health insurance issuer shall accept either of the following at the sole discretion of the health insurance issuer:

(a) The current version of the Louisiana Standardized Credentialing Application Form, or its successor; or

(b) The current format used by the Council for Affordable Quality Healthcare (CAQH), or its successor.

(4) The commissioner, at his discretion, is hereby authorized and may, for good cause shown, by rule or regulation promulgated pursuant to the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., exempt a health insurance issuer from the requirements of the provisions of Paragraph (3) of this Subsection for any period of time.

C. Nothing in this Section shall be construed to require health insurance issuer credentialing or approval in determining inclusion or participation in an issuer's health insurance plan or policy of health insurance coverage for reimbursement of the rendering of treatment to an enrollee or insured by a religious nonmedical practitioner who furnishes only religious nonmedical treatment or religious nonmedical nursing care.

D. The provisions of this Section shall apply to a preferred provider organization as defined in R.S. 40:2202(5) which engages in credentialing or recredentialing of a provider applicant for approval to provide health care services in its network of providers.

E. The commissioner shall, as a courtesy to health insurance issuers and health care providers, maintain on the Department of Insurance's website both of the following:

(1) The current version of the Louisiana Standardized Credentialing Application Form or its successor.

(2) An electronic link to the current format used by the Council for Affordable Quality Healthcare (CAQH) or its successor.

Added by Acts 2004, No. 671, §1, eff. November 1, 2004; Acts 2005, No. 374, §1.

§12. Billing audit guidelines, rules, and regulations

A. The commissioner shall, with the consent of the Department of Health and Hospitals and in compliance with the Louisiana Administrative Procedure Act, issue such rules, regulations, and orders as shall be necessary to implement a statewide system of billing audit guidelines of health care bills for medical and clinical items and their reimbursement by insurers, health maintenance organizations, preferred provider organizations, self-insured plans, or any other medical expense plan or contract.

B. The rules, regulations, or orders required by Subsection A shall determine:

(1) The need to bill or rebill a payor of medical or clinical care charges that were not initially incorporated on a reimbursement or payment claim by a provider.

(2) The need to adjust reimbursements and payments undertaken by the payor for items or services that were insufficiently documented.

(3) The need to periodically validate the accuracy of the billing process between provider and payor.

C. The rules, regulations, and orders required by Subsection A shall include but not be limited to the following parameters:

(1) Exceptions to the rules, regulations, and orders in cases where there exists a negotiated contract between the auditing parties.

(2) An audit fee of one hundred dollars.

(3) Initial payment criteria and alternatives available upon mutual agreement.

(4) Guidelines/qualifications of both internal and external auditors.

(5) Provisions for the payment for any identified unsupported or unbilled charges discovered by the audit parties.

D. The term "billing audit" means a process to determine whether data in a health care record of a provider is supported by services or treatments listed on the bill issued by the provider.

Acts 1993, No. 664, §1.

§13. Violations reported by employees; retaliation by insurer prohibited

A. Any insurer transacting business in this state is prohibited from penalizing any of its employees for reporting to the commissioner of insurance or other appropriate authorities, in good faith, a suspected violation of this Code, or any law in Title 22 of the Louisiana Revised Statutes of 1950 relative to required reserves, capital, assets, deposits, minimum and operating surplus, investments, and separate accounts of entities regulated by the Department of Insurance, illegal discrimination against a person, or other prohibitory provisions that provide criminal penalties for their violation, or any rule with criminal sanctions adopted by the commissioner of insurance. For purposes of this Section, "penalize" or "penalizing" shall include:

(1) Discharging, disciplining, demoting, transferring, or otherwise discriminating against an employee of the insurer.

(2) Reducing the benefits, pay, or work privileges of an employee of the insurer.

(3) Preparing a negative work performance evaluation of an employee of the insurer.

(4) Threatening to take any of the actions described in Paragraphs (1) through (3) above.

B. Whenever the commissioner of insurance, a state agency, or law enforcement agency conducts an investigation based upon a written sworn report or with the participation of an employee as provided in this Section, it may not disclose the identity of the employee without the employee's consent. If it is determined that such disclosure is required for an administrative proceeding or criminal prosecution based upon the findings of the investigation, then the person or entity conducting the investigation shall notify the employee prior to disclosure of the employee's identity. Any proceeding or hearing by the commissioner of insurance under this Section shall be conducted in accordance with R.S. 22:1351 et seq.

C. Any employee who makes a written sworn report on the activities of an insurer, as described in this Section, to the commissioner of insurance or appropriate authority, is not subject to civil liability for making the report and no civil cause of action may arise against the employee for making the report. This immunity shall apply provided that the information available to the employee would support a reasonable belief that the activity, policy, or practice reported violates this Code, a rule, or the law as described above, or impairs or endangers the solvency of the insurer. No such immunity shall apply to any report that is fraudulent or made in bad faith. Employees who intentionally make fraudulent reports or make reports in bad faith shall be guilty of the crime of false swearing and subject to the penalties provided for in R.S. 14:125.

D.(1) To the extent necessary to protect the anonymity of the employee who makes a written sworn report under this Section, the records of the commissioner of insurance or other state or law enforcement agency referring to the report shall be confidential for purposes of the state public records laws and are not subject to inspection or copying as a public record.

(2) The Department of Insurance shall report the name of the employee to the insurer if the statement is determined by the commissioner of insurance to be false or made in bad faith.

E. In addition to any other applicable penalties, any insurer found to be in violation of this Section shall be subject to a fine not to exceed ten thousand dollars.

Acts 1993, No. 1033, §1.

§14. Central database for contact information on life insurance policies

A. The Department of Insurance shall maintain a central database of electronic contact information for each life insurer having policies in force in this state.

B. On and after January 1, 2004, any member of the immediate family of a decedent searching for life insurance policies covering the decedent may file a written request with the department for a search pursuant to this Section, provided the decedent was a resident or former resident of this state. Any such request shall include a copy of the subject decedent's death certificate. The right to file a written request for a search pursuant to this Section may not be assigned.

C. The department shall transmit any such request to all life insurers having policies in force in this state, along with information necessary for responding directly to the person filing the request. Each such insurer shall examine its books and records to make a determination as to the existence of coverage of the subject decedent, and upon a finding that such coverage does exist, shall directly notify the person filing the request.

D. The commissioner of insurance may adopt such rules and regulations as may be necessary to implement the provisions of this Section.

E. Insurers of credit life insurance, as defined in R.S. 22:6(16)(a), are exempt from inclusion in the central database and shall not be subject to the requirements of this Section.

Added by Acts 2003, No. 1224, §1; Acts 2004, No. 838, §1.

§15. Louisiana Property and Casualty Insurance Commission

A. The legislature hereby creates the Louisiana Property and Casualty Commission within the Louisiana Department of Insurance. The functions, duties, and responsibilities of the commission shall be to review and examine the availability and affordability of property and casualty insurance in the state of Louisiana. Further, the commission shall undertake a comprehensive study and provide oversight and enforcement recommendations of the effectiveness of law enforcement and implementation of programs aimed at enforcement throughout the state of those laws and programs which affect automobile insurance rates.

B The commission shall be domiciled in the city of Baton Rouge and its members shall serve for terms of two years beginning July 1, 2001.

C. The commission shall consist of the following members:

(1) The governor or his designee.

(2) Repealed by Acts 2003, No. 590, §2.

(3) The assistant secretary of the Louisiana Department of Public Safety and Corrections, office of motor vehicles, or his designee.

(4) The attorney general or his designee.

(5) A representative of the Louisiana Association of Fire and Casualty Companies, selected by its governing body, or his designee.

(6) The president of the Louisiana District Attorneys Association or his designee.

(7) A representative of the National Association of Independent Insurers, selected by its governing body, or his designee.

(8) The chairperson of the Louisiana Insurance Rating Commission or his designee.

(9) Two members of the House Committee on Insurance selected by its chairman.

(10) Two members of the Senate Committee on Insurance selected by its chairman.

(11) One consumer representative selected by the speaker of the House of Representatives.

(12) One consumer representative selected by the president of the Senate.

(13) A representative of the Independent Insurance Agents of Louisiana.

(14) A representative of the Professional Insurance Agents of Louisiana.

(15) The executive director of the Louisiana Highway Safety Commission or his designee.

(16) A representative of the Property Insurance Association of Louisiana appointed by its governing committee or his designee.

(17) A representative of the Louisiana Workers' Compensation Corporation appointed by its board of directors or his designee.

(18) A representative of the Department of Labor, office of workers' compensation or his designee, appointed by the secretary of labor.

(19) The commissioner of insurance or his designee.

(20) A representative of the Alliance of American Insurers, selected by its governing body, or his designee.

(21) A representative of law enforcement or his designee, selected jointly by the superintendent of state police, the secretary of the Department of Public Safety and Corrections, the president of the Louisiana Association of Chiefs of Police, and the president of the Louisiana Sheriff's Association.

D. The commission shall consist of ad hoc committees to study property and casualty insurance, including but not limited to the areas of automobile insurance, homeowners insurance, and workers' compensation insurance. The commissioner of insurance shall appoint a chairperson and a vice chairperson for the commission and a chairperson and vice chairperson for each ad hoc committee.

E. The automobile insurance ad hoc committee shall consist of the following members:

(1) The commissioner of insurance or his designee.

(2) The governor or his designee.

(3) Repealed by Acts 2003, No. 590, §2.

(4) The assistant secretary of the Louisiana Department of Public Safety and Corrections, office of motor vehicles, or his designee.

(5) The attorney general or his designee.

(6) The representative of the National Association of Independent Insurers or his designee.

(7) The representative of the Louisiana Association of Fire and Casualty Companies or his designee.

(8) The president of the Louisiana District Attorneys Association or his designee.

(9) The executive director of the Louisiana Highway Safety Commission.

(10) Two members of the Senate Committee on Insurance selected by its chairman.

(11) Two members of the House Committee on Insurance selected by its chairman.

(12) One consumer representative selected by the speaker of the House of Representatives.

(13) One consumer representative selected by the president of the Senate.

(14) A representative of the Independent Insurance Agents of Louisiana.

(15) A representative of the Professional Insurance Agents of Louisiana.

(16) The chairperson of the Louisiana Insurance Rating Commission or his designee.

(17) A representative of the Alliance of American Insurers, selected by its governing body, or his designee.

(18) The representative of law enforcement or his designee.

F. The homeowners ad hoc committee shall consist of the following members:

(1) The governor or his designee.

(2) The commissioner of insurance or his designee.

(3) Two members of the Senate Committee on Insurance selected by its chairman.

(4) Two members of the House Committee on Insurance selected by its chairman.

(5) A representative of the Independent Insurance Agents of Louisiana.

(6) A representative of the Professional Insurance Agents of Louisiana.

(7) The chairperson of the Louisiana Insurance Rating Commission or his designee.

(8) One consumer representative selected by the speaker of the House of Representatives.

(9) One consumer representative selected by the president of the Senate.

(10) A representative of the Property Insurance Association of Louisiana appointed by its governing committee or its designee.

(11) The representative of the Louisiana Association of Fire and Casualty Companies or his designee.

(12) The representative of the National Association of Independent Insurers or his designee.

G. The workers' compensation insurance ad hoc committee shall consist of the following members:

(1) The governor or his designee.

(2) The commissioner of insurance or his designee.

(3) Two members of the Senate Committee on Insurance selected by its chairman.

(4) Two members of the House Committee on Insurance selected by its chairman.

(5) A representative of the Independent Insurance Agents of Louisiana.

(6) A representative of the Professional Insurance Agents of Louisiana.

(7) The chairperson of the Louisiana Insurance Rating Commission or his designee.

(8) One consumer representative selected by the speaker of the House of Representatives.

(9) One consumer representative selected by the president of the Senate.

(10) A representative of the Louisiana Workers' Compensation Corporation appointed by its board of directors or his designee.

(11) A representative of the Department of Labor, office of workers' compensation or his designee, appointed by the secretary of labor.

(12) The representative of the National Association of Independent Insurers or his designee.

(13) A representative of the Alliance of American Insurers, selected by its governing body, or his designee.

H. The members of the commission shall serve without compensation, and their terms shall be for two years.

I. Any vacancies on the commission shall be filled in the same manner as the original appointments for the unexpired portion of the term of the vacated appointment.

J. A majority of the members of the commission shall constitute a quorum for the transaction of business. A majority of the members of an ad hoc committee shall constitute a quorum for the transaction of business of the ad hoc committee. All official actions of the commission or any ad hoc committee shall require the affirmative vote of a majority of the members of the commission or ad hoc committee present and voting during meetings of the commission or ad hoc committee. The commission shall meet twice annually in any one calendar year and the ad hoc committees may meet on the call of the chairperson of the commission or of the ad hoc committee, or upon the request of any three members of the ad hoc committee.

K.(1) The commission shall submit to the governor, the Louisiana Legislature, and the commissioner of insurance on an annual basis prior to the convening of each regular legislative session an annual report on their actions, studies, findings, and recommendations of those laws and projects affecting property and casualty insurance.

(2) (a) The commission shall conduct all meetings and hearings, in accordance with R.S. 42:4.1 et seq., to receive testimony about that information it is charged with gathering. The commission shall also be permitted to receive further information and testimony from regional and national experts on insurance rating issues. The commission shall study ways to give incentives to those communities that have a greater enforcement rate over laws that directly or indirectly affect insurance rates in that community and state.

(b) All state and local agencies and political subdivisions shall cooperate with the commission and assist it in the gathering of information when requested. All materials in the possession or control of the commission or its employees shall be considered public records pursuant to R.S. 44:1 et seq.

L. The commissioner of insurance shall appoint a director and an assistant director with the consent of the Senate who shall serve at the pleasure of the commissioner. The commissioner of insurance may also employ such persons, including two unclassified employees, as necessary to carry out the provisions of this Section and may establish the compensation of technical, professional, and clerical employees as needed for the commission to accomplish its work. Any such employee shall be compensated from the budget of the commissioner. All of the employees of the commission shall be under the direction and supervision o f the commissioner of insurance.

Acts 1997, No. 1433, §1; Acts 1999, No. 885, §§1, 3, eff. June 30, 1999; Acts 2001, No. 187, §1, eff. July 1, 2001; Acts 2003, No. 590, §§1 and 2.

PART I-A. PILOT PROGRAMS

§21. Pilot programs; Department of Insurance; establishment

The Department of Labor and the Department of Insurance, conjunctively, after consultation with the office of workers' compensation administration in the Department of Labor, are hereby authorized to establish no more than five pilot health insurance programs, which may consist of groups or associations of employers for twenty-four-hour insurance coverage that shall terminate five years after the first date of operation of the program, unless extended by an act of the legislature. The pilot program shall monitor the medical, hospital, and remedial care of employees and the provision of prompt, effective care and earlier restoration of earning capacity without diminution of the quality of that care of the injured or disabled employee. In order to implement the pilot health insurance program for employees, the Department of Labor and the Department of Insurance, conjunctively, shall:

(1) Initiate an initial pilot project for reimbursement to hospitals on diagnostic-related groups upon determination that it is cost-effective and a statistically valid method for reimbursement.

(2) Establish alternate delivery systems using a health maintenance organization model, which includes physician fees, competitive bidding, or capitation models.

(3) Provide for the selection of providers of medical, hospital, and remedial care and utilization review procedures established pursuant to R.S. 40:2725 to control the utilization of care by physicians providing treatment pursuant to R.S. 23:1121 through 1212.

(4) Establish by written agreement all appropriate fees for medical, hospital, and remedial care pursuant to pertinent worker's compensation laws.

(5) Promote effective and timely utilization of medical, hospital, and remedial care of and by insured persons under the pilot program.

(6) Coordinate the duration of payment of disability benefits with a determination by qualified participating providers of medical, hospital, or remedial care.

(7) Establish other methods of monitoring the reduction of costs within the worker's compensation system for health and disability care while maintaining a quality of care.

(8) Provide public input and comment concerning the benefits, deductibles, pre-existing conditions exclusions, and related components of the health care portion of the twenty-four-hour employee insurance pilot program.

Acts 1993, No. 656, §1; Acts 1997, No. 1097, §1, eff. July 14, 1997.

§22. Pilot program; certain provisions

A. The Department of Labor and the Department of Insurance, conjunctively, may negotiate and enter into such contracts or agreements as may be necessary or appropriate to implement the pilot program herein.

B. The Department of Labor and the Department of Insurance, conjunctively, may also accept grants and monies from any source as allowed by law and may expend such grants and monies for the purposes of the program.

C.(1) No provision of the pilot program shall vary the methods for calculating weekly payments for disability compensation required under R.S. 23:1221 et seq.

(2) No provision of the pilot program shall limit or abrogate the right to a hearing concerning benefits, coverage, or quality of care under state law. Furthermore, each pilot program shall incorporate within its terms all provisions of the Louisiana Workers' Compensation law including but not limited to the employee's rights with respect to selection of health care providers.

(3) Except as otherwise provided in Paragraph (2) of this Subsection, all pilot health insurance programs under this Section shall be subject to the provisions of R.S. 23:1121 through 1127.

D. The Department of Labor and the Department of Insurance, conjunctively, shall issue an interim report on or before December 1, 1994, and a final report on or before the termination date of August 15, 1995, to the speaker of the House of Representatives, the president of the Senate, the members of the respective committees on insurance in the House of Representatives and Senate, and the governor, on its activities, findings, and recommendations about the pilot program herein. The Department of Labor and the Department of Insurance, conjunctively, shall monitor, evaluate, and report the following information regarding physicians, hospitals, facilities, and other medical care providers:

(1) Cost savings.
(2) Effectiveness.
(3) Effect on earning capacity and indemnity payments.
(4) Complaints from injured workers and providers.
(5) Concurrent review of quality of care.
(6) Other pertinent matters.

E. The information from the pilot program shall be reported in a format to permit comparisons to other similar data or states.

Acts 1993, No. 656, §1; Acts 1997, No. 1097, §1, eff. July 14, 1997.

§23. Pilot program; requirements, contents

A. Every employer under the pilot program shall secure the payment of compensation by obtaining a twenty-four-hour health insurance policy which shall provide medical benefits authorized by R.S. 22:21 through 22 and which shall meet criteria established conjunctively by the Department of Labor and the Department of Insurance by rule or regulation, promulgated pursuant to the Administrative Procedure Act.[1]

B. The twenty-four-hour health insurance policy herein may provide for health care by a health maintenance organization established by R.S. 22:2001 et seq. or a preferred provider organization established pursuant to R.S. 40:2201 et seq.

C.(1) The premiums for any non-occupational portion of a health insurance policy under this Section may be shared by the employer and employees in accordance with the terms of the policy or plan. All premiums for the workers' compensation portion of the pilot program shall be paid by the employer as required under R.S. 23:1163.

(2) The insurer of any pilot program under this Section shall maintain records to assure compliance with Paragraph (1) of this Subsection.

D. The twenty-four-hour health insurance policy may utilize deductibles and coinsurance provisions that require the employee to pay a portion of the actual medical services received by the employee. However, such policy shall exempt the employee from deductibles and coinsurance provisions related to work or occupational injuries or diseases.

E. In the event the employer purchases a twenty-four-hour health insurance policy to secure payment of compensation as to medical benefits, the employer shall also obtain an insurance policy which shall provide indemnity benefits, so that the total coverage afforded by both the twenty-four-hour health insurance policy and the policy providing indemnity benefits, shall provide the total compensation required by state law.

F. Any insurance policy issued under a pilot program shall insure the employer's obligation to a named insured throughout the entire period of any illness or disability, specifically, but not limited to the duration of benefits as provided under the Louisiana Workers' Compensation law or the Louisiana Insurance law for an employee and his dependents.

Acts 1993, No. 656, §1; Acts 1997, No. 1097, §1, eff. July 14, 1997.

[1]R.S. 49:950 et seq.

PART I-B. UNINSURED MOTORIST IDENTIFICATION DATABASE

§25.1. Database development; authorization; request for proposals

A. The commissioner of the Department of Insurance shall formulate criteria to develop and initiate a request for proposals to procure and implement a real-time system to quickly and accurately identify and verify the existence of motor vehicle insurance or other security required in compliance with the Motor Vehicle Safety Responsibility Law using advanced telecommunications and computer technology.

B. The request for proposal shall require participants to perform the following:

(1) Create and maintain a database, at no cost to the state, of motor vehicles registered in this state which are covered by that security required to operate a motor vehicle in this state as provided in the Motor Vehicle Safety Responsibility Law.

(2) Provide real-time access to state and local law enforcement officials responsible for enforcing the traffic laws of this state which shall be available twenty-four hours a day, seven days a week.

C. The database may be initially implemented by the commissioner of the Department of Insurance as a two-year pilot program to be developed and implemented statewide upon expiration of the two-year period.

D. The commissioner shall require such information as may be necessary from automobile insurers or their representatives and the state treasurer as is needed to assist the contractor in creating and developing the database as such relates to the cancellation or issuance of motor vehicle liability security required in R.S. 32:863.2 or the deposit of sufficient security with the state treasurer in order to operate a motor vehicle in this state.

E. The commissioner of the Department of Insurance shall promulgate rules and regulations to implement the provisions of this Part.

Acts 2003, No. 790, §1.

§25.2. Disclosure of insurance information

A. Information in the database shall not be disclosed to any person or entity except as provided in this Section. Information in the database shall be disclosed by the contractor only in the following situations:

(1) To the individual operator or owner of a vehicle concerning information about him or her in the database.

(2) To state or local law enforcement officials involved in investigating or enforcing the traffic laws of this state to determine compliance with the Motor Vehicle Safety Responsibility Law.

(3) To any state or local governmental official investigating a motor vehicle accident but only to determine whether a party involved in such accident is in compliance with the Motor Vehicle Safety Responsibility Law.

(4) To any person designated in a notarized affidavit signed by the individual about whom the information is sought granting his or her consent to the release of such information.

B. No insurer or person acting on behalf of a motor vehicle liability insurer shall be liable to an insured for information submitted in compliance with the requirements of this Part.

Acts 2003, No. 790, §1.

PART II. DOMESTIC INCORPORATED INSURERS

§31. Incorporators

Five or more natural persons of full age, or fully relieved by emancipation of all disabilities attaching to minority, who are citizens of the United States and a majority of whom are residents of this state, may form a corporation for the purpose of transacting any class or classes of insurance permitted under this code as a stock or mutual company.

Acts 1958, No. 125.

§32. Articles of incorporation

Articles of incorporation shall be executed by authentic act signed by each of the incorporators and shall state in the English language:

(1) The name of the corporation, which shall not be the same as nor deceptively similar to the name of any other domestic insurer or of any alien or foreign insurer authorized to do business in this state unless (a) such other domestic, alien or foreign insurer is about to change its name or to cease to do business or is being wound up, or such foreign corporation is about to withdraw from doing business in this state, and the written consent of such other insurer to the adoption of its name or a deceptively similar name has been given in writing and is filed with the articles, or (b) such other insurer has heretofore been authorized to do business in this state for more than two years and has never actively engaged in business;

(2) The purpose or purposes for which it is formed;

(3) Its duration;

(4) The location and post office address of its registered office;

(5) The full names and post office addresses of its registered agents for service of process;

(6) The amount of paid in capital and minimum surplus, or initial fund, with which the corporation will begin business;

(7) If a stock company, the number of shares, the amount of each share, the time when and the manner in which payment on stock subscribed shall be made;

(8) The names of the first directors, their post office address, and their classification and terms of office if they be named in the articles. Where the first board of directors is not named in the articles, the articles shall provide the place where, the date when the organization is to be perfected, and a meeting of the stockholders or policyholders for that purpose must be held not more than sixty days after the execution of the articles. At that meeting the directors shall be elected;

(9) The name and post office address of each of the incorporators, and, if a stock company, a statement of the number and class of shares subscribed by each, which shall not be less than one;

(10) The designation of general officers, the number of directors, which shall not be less than five nor more than fifty, and the mode and manner in which directors shall be elected, and officers elected or appointed;

(11) Any other provision for the regulation of the business and the conduct of the affairs of the corporation, not prohibited by this code or the other laws of this state.

Acts 1958, No. 125.

§33. Approval of articles

Such articles shall be submitted to the commissioner of insurance for his examination and approval either before or after execution, but before recordation. The commissioner shall not approve such articles unless they strictly conform with the provisions of the Louisiana Insurance Code, being Title 22 of the Louisiana Revised Statutes of 1950.

Acts 1958, No. 125. Amended by Acts 1979, No. 152, §1.

§34. Recordation

A. The articles, or a multiple original thereof, after having been submitted to and approved by the commissioner of insurance, shall be recorded in the office of the recorder of mortgages of the parish in which the registered office of the corporation is situated and two certified copies of the articles, bearing the certificate of the proper recorder of mortgages, showing the date and hour when the articles were filed for record in his office, shall be delivered to the commissioner of insurance and one of said copies recorded in his office; and when all taxes, fees and charges have been paid as required by law, the commissioner of insurance shall certify the date and hour when the corporate existence began, according to the certificate of the recorder of mortgages showing the date and hour when the original articles were filed for record in the office of such recorder.

B. The corporation shall not have authority to transact an insurance business until a certificate of authority to transact such business is issued to it by the commissioner of insurance.

C. The secretary of state is authorized and directed to transfer to the commissioner of insurance the articles of incorporation, and all amendments thereto, of domestic incorporated insurers now holding or hereafter issued certificates of authority to transact the business of insurance in this state, as well as such other records as may pertain to such insurers, after having first reproduced such articles, amendments and records for preservation in the office of the secretary of state.

Acts 1958, No. 125. Amended by Acts 1960, No. 391, §1; Acts 1999, No. 342, §6.

§35. Application for certificate of authority

An application shall be made by the first directors to the commissioner of insurance for a certificate of authority which shall be accompanied by:

(1) A copy of the acceptance of trust duly executed by each director.

(2) A copy of the oath of office taken by each officer.

(3) A statement verified by the oath of its president and its secretary, showing that said company is duly organized and that its funds are invested as required by law.

(4) An agreement signed by its president and secretary to abide by and comply with the rates, except for life, health and accident insurance, rules and regulations formulated and adopted by the commissioner of insurance or any duly authorized state board or commission.

(5) An appointment of at least one agent in this state.

(6) A copy of the bylaws, which in case of a mutual insurer must specify the minimum and maximum contingent liability of its policyholders for the payment of losses incurred under its policies.

(7) Organization bonds, if required.

(8) A statement verified by the oath of its president and its secretary, disclosing the identity and percentage of ownership of the company owners.

(9) Biographical background information, on a form prescribed by the commissioner, for each owner of a controlling interest, at least ten percent ownership, for each director, and for each officer.

(10) An agreement, at least three consecutive years in duration, signed by its president, engaging an independent qualified auditor who is a member in good standing with either the American Institute of Certified Public Accountants or with the Society of Financial Examiners which has designated the auditor as a certified financial examiner, to provide the commissioner an annual audited financial statement as required by the commissioner.

(11)(a) If a property or casualty insurer, an agreement, at least three consecutive years in duration, signed by its president engaging an independent qualified actuary who is a member in good standing of the American Academy of Actuaries or the Casualty Actuarial Society, to provide to the commissioner an annual actuarial reserves analysis as required by the commissioner.

(b) If a life or health insurer, an agreement, at least three consecutive years in duration, signed by its president engaging an independent qualified actuary who is a member in good standing of the American Academy of Actuaries, to provide to the commissioner an annual actuarial reserves analysis as required by the commissioner.

(c) The commissioner may adopt rules and regulations to implement the provision herein, pursuant to the Administrative Procedure Act.

Acts 1958, No. 125; Acts 1989, No. 604, §1, eff. Sept. 1, 1989; Acts 1991, No. 771, §1; Acts 1992, No. 704, §1.

§36. REPEALED BY ACTS 2001, No. 487, §1.

§37. Initial examination: issuance of certificate of authority

Upon receipt of the application for a certificate of authority, the commissioner of insurance shall cause an initial examination to be made of the corporation. If, in the opinion of the commissioner of insurance, the examination shows the corporation to be duly organized and to have complied with all requirements of law, he shall notify the applicant and issue a certificate of authority to the corporation.

Acts 1958, No. 125.

§38. Amendment to articles of incorporation

A. An incorporated insurer may, at a meeting of the shareholders or members duly called upon notice for this specific purpose and in the manner herein provided, amend its articles of incorporation. Such amendment altering the articles may be adopted by the vote of the holders of two-thirds of the voting power of all persons present or represented by proxy entitled under the articles to vote.

B. After the amendment has been duly adopted, an authentic act setting forth the amendment and the manner of adoption thereof shall be executed by such person or persons authorized to do so at the meeting. A full copy of the minutes of the meeting at which such amendment was adopted, certified as a true copy by the secretary of the insurer or of the meeting, shall be annexed to the authentic act. The articles of amendment or multiple originals thereof shall be approved and recorded in the same manner as that provided herein for the original articles of incorporation.

C. The provisions of Subsections A and B of this Section shall not be applicable when an incorporated insurer changes either its registered agent or address, or both. In any such change, the incorporated insurer shall provide the commissioner of insurance with the board resolution and notice, in the manner provided for by Part III of Chapter 1 of Title 12 of the Louisiana Revised Statutes of 1950.

Acts 1958, No. 125. Acts 1983, No. 305, §1.

§39. Books and records of domestic insurer; securities

A. Every domestic and redomesticated insurer shall keep its books, records, documents, accounts, and vouchers in such manner that its financial condition, affairs, and operations can be ascertained and so that its financial statements filed with the commissioner can be readily verified and its compliance with the law determined. Such insurer may cause any or all such books, records, documents, accounts, and vouchers to be photographed or reproduced on film. Any such photographs, microphotographs, optical imaging, or film reproductions of any original books, records, documents, accounts, and vouchers shall for all purposes be considered the same as the originals thereof and a transcript, exemplification, or certified copy of any such photograph, microphotograph, optical imaging, or film reproduction shall for all purposes be deemed to be a transcript, exemplification, or certified copy of the original. Any original so reproduced may thereafter be disposed of or destroyed, as provided for in Subsection B of this Section, if provision is made for preserving and examining such reproductions.

B. All such original books, records, documents, accounts, and vouchers, or such reproductions thereof, of the home office of any domestic company or of any principal United States office of a foreign or alien company located in this state shall be preserved and kept available in this state for the purpose of examination and until authority to destroy or otherwise dispose of such records is secured from the commissioner. At a minimum all such original records shall be maintained for the period commencing on the first day following the last period examined by the commissioner through the subsequent examination period, or three years, whichever is greater. Such original records may, however, be kept and maintained outside this state if, according to a plan adopted by the company's board of directors and approved by the commissioner, it maintains suitable records in lieu thereof.

C. Every domestic company shall keep its securities within the state of Louisiana except where:

(1) On deposit with other states of the United States of America, or political subdivision thereof.

(2) On deposit with foreign countries where the company is licensed to transact an insurance business.

(3) Required for the normal transaction of the company's business and approved by the commissioner.

D. Any domestic company may maintain for its securities a limited agency, custodial or depository account, or other type of account for the safekeeping of those securities; collecting the income from those securities; and providing supportive accounting services relating to such safekeeping and collection; all provided the domestic company maintains full investment discretion over those securities. Such account shall be with either (1) a bank, qualified under state law to administer trusts in this state, and operating as described in R.S. 6:534(B); or (2) a member of the National Association of Securities Dealers, subject to the jurisdiction of the Securities and Exchange Commission, maintaining membership in the Securities Investors Protection Corporation, and having an agency office in this state. The bank or the National Association of Securities Dealers member, in safekeeping such securities, shall have all the powers, rights, duties, and responsibilities as it has under state law for holding securities in its fiduciary accounts. The commissioner of insurance is hereby authorized to promulgate rules and regulations pursuant to this Subsection.

E. Any director, officer, agent, or employee of any company who destroys any such books, records, or documents without the authority of the commissioner in violation of this Section or who fails to keep the books, records, documents, accounts, and vouchers required by this Section shall be fined not more than five thousand dollars.

F. The commissioner of insurance may require that any domestic or redomesticated insurer maintaining its books, records, documents, accounts, and vouchers outside of this state pursuant to this Section shall, upon notice of a pending examination by the commissioner, deposit with the Department of Insurance such funds as the commissioner shall estimate as necessary for the conduct of the examination, including all expenses as set forth in R.S. 22:1304. The funds so deposited shall be maintained by the commissioner in a separate account for the purpose of paying such expenses during the progress of the examination as he may deem appropriate. The commissioner may require additional deposits where the expenses exceed the original estimate.

Added by Acts 1979, No. 115, §1 Acts 2001, No. 302, §1; Acts 2004, No. 342, §1.

§40. Business Corporation Law governs when Insurance Code silent

The provisions of the Louisiana Business Corporation Law, as provided in R.S. 12:1 through R.S. 12:178, and other provisions of said Title 12 relative to business corporations, shall apply to the regulation of the business and the conduct of the affairs of any domestic insurer which has been incorporated pursuant to the provisions of Parts II and III of Title 22 of the Louisiana Revised Statutes, in those situations in which the provisions of said Title 22 are silent. If a conflict exists between the provisions of said Title 22 and said provisions of Title 12, the provisions of the Louisiana Insurance Code shall govern.

Added by Acts 1981, No. 715, §1.

PART III. DOMESTIC STOCK INSURERS

§71. Capital requirements; applicants prior to September 1, 1989

A. Domestic stock insurers who apply for a certificate of authority prior to September 1, 1989, may transact the following kinds of insurance in this state upon qualifying therefor and by having paid-in capital and minimum surplus represented by assets as follows:

	Insurance	Paid-in Capital	Minimum Surplus
(1)	Life	$ 100,000	$ 200,000
(2)	Health and accident	100,000	200,000
	(1) and (2) above	100,000	200,000
(3)	Vehicle physical damage	100,000	150,000
(4)	Title		
	(a) Any company licensed to transact title insurance prior to September 1, 1985	50,000	25,000
	(b) Any company licensed to transact title insurance on or after September 1, 1985	100,000	200,000
(5)	Industrial fire	200,000	100,000
(6)	Any company organized and authorized to transact worker's compensation only as of July 27, 1966	100,000	50,000
(7)	Any company organized and authorized to transact crop and livestock insurance only as of July 27, 1966	100,000	150,000
(8)	Vehicle	650,000	350,000
(9)	Liability	650,000	350,000
(10)	Worker's compensation	650,000	350,000
(11)	Burglary and forgery	650,000	350,000
(12)	Glass	650,000	350,000
(13)	Fidelity and surety	650,000	350,000
(14)	Fire and extended coverage	650,000	350,000
(15)	Steam boiler and sprinkler leakage	650,000	350,000
(16)	Crop and livestock	650,000	350,000
(17)	Marine and transportation	650,000	350,000
(18)	Miscellaneous	650,000	350,000
(19)	All insurances, except life and	650,000	350,000
	title or combined capital and surplus	1,000,000	

For the purpose of this Section, "vehicle physical damage insurance" shall be defined as insurance against loss or damage to any land vehicle or property while contained therein or thereon or being loaded or unloaded therein or therefrom.

B. Authority shall be granted stock insurers upon compliance with all applicable requirements to transact combinations of kinds of insurance except as follows:

(1) An insurer authorized to transact life insurance shall not be authorized to transact any additional kind of insurance other than health and accident insurance.

(2) An insurer authorized to transact title insurance shall not be authorized to transact any additional kind of insurance.

C. Domestic stock insurers who apply for a certificate of authority on or after September 1, 1989, shall meet the paid-in capital, minimum surplus, operating surplus, and other requirements of R.S. 22:71.1.

Acts 1958, No. 125. Amended by Acts 1958, No. 101, §1; Acts 1960, No. 139, §1; Acts 1966, No. 234, §1; Acts 1980, No. 470, §1; Acts 1980, 2nd Ex.Sess., No. 6, §1, eff. Sept. 15, 1980; Acts 1983, 1st Ex.Sess., No. 1, §6; Acts 1985, No. 718, §1, eff. Sept. 1, 1985; Acts 1989, No. 562, §1.

§71.1. Capital requirements; applicants on and after September 1, 1989

A. Domestic stock insurers which apply for a certificate of authority on or after September 1, 1989, may transact the following kinds of insurance in this state upon qualifying therefor and by having paid-in capital, minimum surplus, and operating surplus represented by assets as follows:

	Insurance	Paid-in Capital	Minimum Surplus	Operating Surplus
(1)	Life	$ 100,000	$ 1,900,000	$ 1,000,000
(2)	Health and accident	100,000	1,900,000	1,000,000
	(1) and (2) above	100,000	1,900,000	1,000,000
(3)	Vehicle physical damage	100,000	1,150,000	1,000,000
(4)	Title	100,000	400,000	500,000
(5)	Industrial fire	200,000	800,000	1,000,000
(6)	Vehicle	650,000	1,350,000	1,000,000
(7)	Liability	650,000	1,350,000	1,000,000
(8)	Worker's compensation	650,000	1,350,000	1,000,000
(9)	Burglary and forgery	650,000	1,350,000	1,000,000
(10)	Glass	650,000	1,350,000	1,000,000
(11)	Fidelity and surety	650,000	1,350,000	1,000,000
(12)	Fire and extended coverage	650,000	1,350,000	1,000,000
(13)	Steam boiler and sprinkler leakage	650,000	1,350,000	1,000,000
(14)	Crop and livestock	650,000	1,350,000	1,000,000
(15)	Marine and transportation	650,000	1,350,000	1,000,000
(16)	Miscellaneous	650,000	1,350,000	1,000,000
(17)	All insurances, except life and title	650,000	1,350,000	1,000,000

B. For the purpose of this Section, "vehicle physical damage insurance" shall be defined as insurance against loss or damage to any land vehicle or property while contained therein or thereon or being loaded or unloaded therein or therefrom.

C. Authority shall be granted stock insurers upon compliance with all applicable requirements to transact combinations of kinds of insurance except as follows:

(1) An insurer authorized to transact life insurance shall not be authorized to transact any additional kind of insurance other than:

(a) health and accident insurance

(b) annuity or

(c) credit life, health, and accident insurance

(2) An insurer authorized to transact title insurance shall not be authorized to transact any additional kind of insurance.

D. For the purpose of this Section, assets representing at least fifty percent of the operating surplus must be maintained in cash or in cash equivalents as prescribed by the commissioner.

Acts 1989, No. 562, §1; Acts 2003, No. 131, §1; Acts 2005, No. 27, §1, eff. June 9, 2005.

§71.2. Additional capital and surplus

The commissioner may require a domestic stock insurer to have and maintain a greater amount of capital and surplus than prescribed in R.S. 22:71 or 71.1, based upon the type, volume, and nature of insurance business transacted. The commissioner is authorized to promulgate such rules and regulations as he may deem necessary to carry out the provisions of this Section.

Acts 1992, No. 811, §1.

§72. Payment for capital stock

A. Capital stock of any insurer shall be paid-in in cash within twelve months from the date of its charter, and no certificate of shares and no policies shall be issued by it until the whole paid-in capital and minimum surplus required and specified in the articles of incorporation are paid in. A majority of the directors shall certify on oath that this requirement has been met and the money paid in is held as the capital of the company to be invested as required by this Code.

B. The stock insurer may borrow a sum of money sufficient to meet additional contributions to surplus which may be required in excess of the minimum capital and surplus stated for a Louisiana insurer, upon agreement with the lender that the loan with interest at a rate not exceeding ten percent per annum shall be repaid only in the event that, after such repayment with interest, the insurer shall be left possessed of sufficient assets to meet all of its liabilities, to maintain a full reserve against all its policies, and to maintain the minimum capital and surplus required by R.S. 22:71. Such debentures must be issued on a form provided or approved by the commissioner of insurance and registered with his office, and all repayments of principal and payment of interest must be approved by the commissioner.

Acts 1958, No. 125. Amended by Acts 1982, No. 341, §1.

§73. Increase in capital stock

A. Any domestic stock insurer may increase the amount of its capital stock upon a vote of two-thirds of its board of directors, ratified by a vote of two-thirds of the stockholders voting, at a meeting called for that purpose, after a notice is published once a week for four consecutive weeks in the official journal of the parish of domicile, and a notice is mailed to each stockholder at least thirty days prior to the date of such meeting. However, the requirement for publication of the meeting notice in the official journal may be waived by unanimous written consent of all stockholders.

B.(1) Upon the completion of the proceedings, the company shall submit to the commissioner of insurance a certificate setting forth the amount of the increase and the fact of the transaction signed and sworn to by its president, secretary, and a majority of its directors.

(2) If the commissioner of insurance finds the facts conform to the law, he shall approve the increase in capital, and the charter shall be amended in the manner specified in R.S. 22:38.

C. Within one year after such meeting of stockholders at which such increase shall be made, the new subscriptions shall be paid in cash, or in assets qualifying for investments for domestic insurance companies as defined in R.S. 22:844, except in the case of stock dividends, and new stock certificates issued.

Acts 1958, No. 125. Amended by Acts 1960, No. 165, §1; Acts 1962, No. 304, §1; Acts 1970, No. 85, §1; Acts 1999, No. 1312, §1, eff. July 12, 1999.

§74. Dividends on stock

No domestic stock insurer shall declare and pay any dividends to its stockholders unless its capital is fully paid in cash and is unimpaired and it has a surplus beyond its capital stock and the initial minimum surplus required and all other liabilities equal to fifteen per cent of its capital stock, provided that this restriction shall not apply to an insurer when its paid-in capital and surplus exceed the minimum required by this Code by one hundred percent or more.

Acts 1958, No. 125.

§75. Stock dividends

Stock dividends may be declared and paid in the manner specified in R.S. 22:73 except that publication of the notice and the payment in cash shall not be required.

Acts 1958, No. 125.

§76. Sales of stock

All sales of stock as defined in this Section shall be made in accordance with the following regulations:

A. When used in this Section, the following terms shall have the following respective meanings:

(1)(a) "Security" as used in this Section shall include any insurance stock, note, stock, treasury stock, bond, debenture, evidence of indebtedness, certificate of interest or participation in any profit-sharing agreement, collateral-trust certificate, preorganization certificate or certificate of deposit for security, any certificate of deposit, or group or index of securities, or, in general, any interest or instrument commonly known as a "security", or any certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase, any of the foregoing issued by an insurance company, an investment, or holding company with a stated purpose, either by charter or prospectus, of forming an insurance company.

(b) For the purpose of this Section, security shall not mean any insurance or endowment policy or annuity contract under which any insurance company promises to pay a fixed number of dollars either in a lump sum or periodically for life or some other specified period nor any variable life or annuity contract as provided for in and regulated by this Title and issued by a life insurance company licensed to do business in the state of Louisiana.

(2) "Person" shall include a natural person, a corporation created under the laws of this state, or of any other state, country, sovereignty, or political subdivision thereof, a partnership, an association, a joint stock company and any unincorporated association or organization.

(3) "Sale" or "sell" shall include every disposition, or attempt to dispose of a security as defined in this section or interest in such a security for value. Any security as defined in this Section given or delivered with, or as a bonus on account of, any purchase of such securities or any other thing, shall be conclusively presumed to constitute a part of the subject of such purchase and to have been sold for value. "Sale" or "sell" shall also include an exchange, an attempt to sell, an option of sale, a solicitation of a sale, a subscription of an offer to sell, directly or by an agent, or a circular, letter, advertisement or otherwise, except an isolated transaction in which any security as defined in this section is sold, offered for sale or delivery by the owner not being made in the course of repeated and successive transactions of a like character by such owner, provided the owner is not the underwriter of such security.

(4) "Dealer" shall include every person, or investment counsel or investment counsellor, as those terms are generally used, other than a salesman, as hereinafter defined, who in this state engages either for all or part of his time, directly or through an agent in the business of selling any securities as defined in this Section issued by another person or purchasing or otherwise acquiring such securities from another for the purpose of re-selling them or of offering them for sale to the public, or offering, buying, selling or otherwise dealing or trading in such securities as principal or agent for a commodity or commission or at a profit, or who deals in futures or differences in market quotations of prices or values of any such securities; provided that the word "dealer" shall not include a person having no place of business in this state who sells or offers to sell securities exclusively to brokers or dealers actually engaged in buying and selling such securities as a business.

(5) "Issuer" shall mean and include every person who proposes to issue, has issued or who shall hereafter issue any security as defined in this Section. Any person who acts as a promoter for and on behalf of a corporation, unincorporated association or partnership of any kind, formed or to be formed, shall be deemed to be an issuer.

(6) "Salesman" shall include every natural person, including insurance agents, other than a dealer, employed or appointed or authorized by a dealer or issuer to sell securities as defined in this section in any manner in this state. The partners of a partnership and the executive officers of a corporation or other corporate entity or association registered as a dealer shall not be salesmen within the meaning of this definition.

(7) "Broker" shall mean dealer as herein defined.

(8) "Agent" shall mean salesman as herein defined.

(9) "Commissioner" shall mean the Commissioner of Insurance of the State of Louisiana.

B. Exempt securities.

Except as hereinafter otherwise expressly provided, the provisions of this Section shall not apply to any of the following classes of securities:

(1) Securities appearing in any list of securities dealt in on the New York or American Stock Exchange, and which securities have been so listed pursuant to official authorization by such exchange, and also all securities senior to any securities so listed, or represented by subscription rights which have been so listed or evidences of indebtedness guaranteed by companies, any stock of which is so listed, such securities to be exempt only so long as such listing shall remain in effect. The commissioner shall have the power to deny this exemption with reference to any particular security listed on any such exchanges, by order published in such manner as the commissioner shall find proper.

(2) Securities appearing in any list of securities dealt in on any other recognized and responsible stock exchange which has been previously approved by the commissioner, and which securities have been so listed pursuant to official authorization by such exchange, and also all securities senior to any securities so listed, or represented by subscription rights which have been so listed, or evidences of indebtedness guaranteed by companies any stock of which is so listed, such securities to be exempt only so long as such listing shall remain in effect. The commissioner shall have power at any time to withdraw approval theretofore granted by him to any exchange, and upon such withdrawal no security listed on such exchange shall be entitled to the benefit of such exemption, unless such security is also listed upon an exchange mentioned in paragraph (1) of this Subsection, and has not been denied this exemption by the commissioner as provided in said paragraph (1) of this Subsection.

(3) Any security, other than common stock, providing for a fixed return which has been outstanding and in the hands of the public for a period of not less than five years, upon which no default in payment of principal or failure to pay the return fixed, has occurred for a continuous immediately preceding period of five years.

C. Except as hereinafter expressly provided, the provisions of this section shall not apply to the sale of any security in any of the following transactions:

(1) At any judicial, executor's, administrator's, tutor's, curator's or liquidator's sale, or at any sale by a receiver, syndic, or trustee in insolvency or bankruptcy.

(2) By or for the account of a pledge holder or mortgagee selling or offering for sale or delivery in the ordinary course of business, and not for the purpose of avoiding the provisions of this Section, to liquidate a bona fide debt, a security pledged in good faith as security for such debt.

(3) An isolated transaction in which any security is sold, offered for sale, subscription or delivery by the owner thereof, or by his representative for the owner's account, such sale or offer for sale, subscription or delivery not being made in the course of repeated and successive transactions of a like character by such owner, or on his account by such representative, and such owner or representative not being the underwriter of such security.

(4) The distribution by a corporation, actively engaged in the business authorized by its charter, of securities to its stockholders or other security holders as a stock dividend or other distribution out of earnings or surplus; or the issuance of securities to the security holders or other creditors of a corporation in the process of a bona fide reorganization or liquidation of such corporation made in good faith and not for the purpose of avoiding the provisions of this Section, either in exchange for the securities of such security holders or claims of such creditors or partly for cash and partly in exchange for the securities or claims of such security holders or creditors; or the issuance of additional capital stock of a corporation sold or distributed by it among its own stockholders exclusively, where no commission or other remuneration is paid or given directly or indirectly in connection with the sale or distribution of such increased capital stock.

(5) The transfer or exchange by one corporation to another corporation of their own securities in connection with a consolidation or merger of such corporations, or in the exchange of outstanding shares for a greater or smaller number of shares of the same corporation.

(6) The sale, transfer or delivery of any securities to any bank, savings institution, trust company, insurance company or to any corporation or to any broker or dealer; provided, that such broker or dealer is actually engaged in buying and selling securities as a business.

(7) The sale by a registered dealer, acting either as principal or agent, of securities theretofore sold and distributed to the public, provided that:

(a) Such securities are sold at prices reasonably related to the current market price thereof at the time of sale, and if such registered dealer is acting as agent, the commission collected by such registered dealer on account of the sale thereof is not in excess of usual and customary commissions collected with respect to securities and transactions having comparable characteristics; and

(b) Such securities do not constitute an unsold allotment to or subscription by such dealer as a participant in the distribution of such securities by the issuer or by or through an underwriter; and

(c) Either Moody's, Standard and Poor's, or Fitch securities manuals, or any other recognized securities manuals approved by the commissioner of insurance, contain the names of the issuer's officers and directors, a balance sheet of the issuer as of a date not more than 18 months prior to the date of such sale, and a profit and loss statement for either the fiscal year preceding that date or the most recent year of operations.

The commissioner may revoke the exemption afforded by this subsection with respect to any securities by issuing an order to that effect if he finds that the further sale of such securities in this state would work or tend to work a fraud on purchasers thereof.

D. No insurance securities or securities in an investment or holding company with a stated purpose, either by charter or prospectus, of forming an insurance company shall be sold within this state unless such securities have been registered as hereinafter defined. Registration of stocks as defined in this Section, shall be deemed to include the registration of rights to subscribe to such stock if the statement under Subsection E of this Section required for registration of such stock includes any provision that such rights are to be issued. A record of the registration of insurance securities or securities in an investment or holding company as hereinabove defined shall be kept in a register of securities to be kept in the office of the commissioner, in which register shall also be recorded any orders entered by the commissioner with respect to such securities. Such registration, and all information with respect to the securities registered in accordance with this Section, shall be open to public inspection.

The commissioner of insurance shall have the right to adopt such rules and regulations as he may deem necessary to carry out the purposes of this Section.

The commissioner of insurance may take depositions, compel production of books and records, subpoena witnesses or documentary evidence, administer oaths and examine under oath any individual relative to the sale of securities as defined in this section. Any person who testifies falsely or makes any false affidavit during the course of such an examination under this Section shall be guilty of perjury.

E. Securities as defined in this section shall be registered by the filing of the issuer, or of any dealer registered with the office of the commissioner of insurance, in the office of the commissioner with respect to such securities of the following:

(1) Name of issuer, location, and, if incorporated, place of incorporation.

(2) A brief description of the security, including amount of the issue.

(3) Amount of securities to be offered in the state.

(4) The par value, the price at which the securities are to be offered for sale to the public, and a statement as to how the proceeds are to be used, including commissions to be paid, which commissions, however, shall in no event exceed fifteen (15%) per cent.

(5) A copy of the circular or prospectus to be used by the issuer or dealer for the public offering.

(6) Any other information or documents required by the commissioner of insurance.

Every statement required to be filed with the commissioner under any of the provisions of this section shall be transmitted by United States mail, and the commissioner shall never receive nor shall he be authorized to receive or accept for filing any statement or documents transmitted to him by any mode other than by United States mail.

The filing of such statement and documents in the office of the commissioner, and the payment of the fee hereinafter provided, shall, after being authorized by the commissioner, constitute the registration of such securities. Upon such registration, such securities may be sold in this state by any registered dealer, subject, however, to the further order of the commissioner as hereinafter provided. Every registration under this section for an insurance company on primary issues of stock shall expire in accordance with the statutory provisions of R.S. 22:73.Every registration under this section for an investment or holding company, or on issued and outstanding shares of stock of an insurance company, shall expire on December 31st of each year, but new registrations for the succeeding period or succeeding year, as the case may be, shall be issued upon written application and upon payment of the fee as hereinafter provided.

If, at any time in the opinion of the commissioner, the information contained in the statement, circular or prospectus filed is, or has become, misleading, incorrect, inadequate or incomplete, or the sale or offering for sale of the security as defined in this section may work or tend to work a fraud, the commissioner may require from the person filing such statement such further information as may in his judgment be necessary to establish the classification of such security as claimed in said statement, or to enable the commissioner to ascertain whether other steps should be taken and the registration rejected or revoked on any ground hereinafter specified, and the commissioner may refuse to register or suspend the right to sell such security pending further investigation by entering an order specifying the grounds for such action, and by notifying by mail, or personally, or by telephone confirmed in writing, or by telegraph, the person filing such a statement and documents, and every registered dealer who shall have notified the commissioner of an intention to sell such security. The refusal to furnish information required by the commissioner within a reasonable time to be fixed by the commissioner may be a proper ground for the entry of such order of suspension. The commissioner shall notify every registered dealer of such order and upon the entry of any such order of suspension no further sales of such security shall be made until the further order of the commissioner.

In the event of the entry of such order of rejection or suspension, the commissioner shall, upon request, give a prompt hearing in accordance with Part XXIX of this Code to the parties interested. If no hearing is requested within a period of twenty (20) days from the entry of such order, or, if upon such hearing the commissioner shall determine that any such security is not entitled to registration under this section, or that the sale thereof should be revoked on any ground hereinafter specified, he shall enter a final order prohibiting sales of such security, with his findings with respect thereto. Until the entry of such final order, the rejection or suspension of the right to sell, though binding upon the persons notified thereof, shall be deemed confidential, and shall not be published, unless it shall appear that the order of suspension has been violated after notice. Appeals from such final order may be taken as hereinafter provided. If, however, upon such hearing the commissioner shall find that the security being offered for sale will neither be fraudulent nor result in fraud, he shall forthwith enter an order revoking such order of suspension and such security shall be restored to its status as a security registered under this section as of the date of such order of suspension.

At the time of filing the statement and documents hereinabove enumerated, and upon re-registration, the applicant shall pay to the commissioner a fee of one-twentieth (1/20) of one (1%) per centum of the aggregate price of such securities to be sold in this state, for which the applicant is seeking registration, but in no case shall such fee be less than twenty-five dollars ($25.00) or more than two hundred dollars ($200.00). The commissioner of insurance is authorized to withhold the funds collected under this section to defray the expenses actually and necessarily incurred by him for salaries and expenses in carrying out the purposes of this section.

F. Revocation of registration of securities as defined in this Section. The commissioner may revoke the registration of any security as defined in this Section by entering an order to that effect, with his findings in respect thereto, if upon the examination into the affairs of the issuer, it shall appear that the company:

(1) Is insolvent, or

(2) Has violated any of the provisions of this Section, or any order of the commissioner of which such issuer has notice, or any of the rules and regulations adopted by the commissioner of insurance under this Section, or

(3) Has been or is engaged or is about to engage in a fraudulent transaction, or

(4) Is in any other way dishonest or has made any fraudulent representations in any prospectus or in any circular or other literature that has been distributed concerning the issuer or its securities, or

(5) Is of bad business repute, or

(6) Does not conduct its business in accordance with law; or

(7) That the affairs of the insurance company or other company issuing such securities are in an unsound condition, or

(8) That the enterprise or business or the security offered is not based upon sound business principles.

In making such examination, the commissioner shall have access to and may compel the production of all the books and papers of such insurance company or other company issuing such securities, subpoena witnesses, and administer oaths to and examine the officers of such issuer, or any expert, whose statement was filed by any issuer in connection with an application, or any other person connected therewith as to its business and affairs, and may also require a balance sheet exhibiting the assets and liabilities of any such issuer or its income statement, or both, to be certified to by a public accountant either of this state, or of any other state approved by the commissioner. The commissioner may also require that any statement made on the authority of any expert be verified by another expert to be selected by the commissioner.

Whenever the commissioner may deem it necessary, he may also require such balance sheets or income statements or statements of experts to be made more specific in such particulars as the commissioner of insurance shall point out, or to be brought down to the latest practicable date.

If any issuer of securities as defined in this Section shall refuse to permit an examination to be made by the commissioner, or if it should refuse or fail to cause, at its own expense, any statement or valuation required to be made by an expert to be verified by another expert selected by the commissioner, it shall be proper ground for revocation of registration.

If the commissioner shall deem it necessary, he may enter an order suspending the right to sell such securities pending any investigation provided that the order shall state the grounds for taking such action.

Notice of the entry of such order shall be given by mail, or personally, or by telephone confirmed in writing, or by telegraph, to the issuer of such securities, which company shall in turn notify every registered dealer.

Before an order is made final, the insurance company or other issuer applying for registration shall on application be entitled to a hearing, and after such hearing the commissioner shall notify it of the final ruling on the matter.

G. Consent to service. Upon any application for registration where the issuer is not domiciled in this state, there shall be filed with such application the irrevocable written consent of the issuer that in suits, proceedings and actions growing out of the violation of any provision of this Section, the service on the commissioner of any notice, process or pleadings therein, authorized by law, shall be as valid and binding as if due service had been made on the issuer. Any such action shall be brought either in the parish of the plaintiff's domicile or in the parish of East Baton Rouge. Said written consent shall be authenticated by the seal of said issuer, if it has a seal, and by the acknowledged signature of a member of the co-partnership or company, or by the acknowledged signature of any officer of the incorporated or unincorporated association, if it be an incorporated or unincorporated association, duly authorized by resolution of the board of directors, trustees or managers of the corporation or association, and shall in such case be accompanied by a duly certified copy of the resolution of the board of directors, trustees or managers of the corporation or association authorizing the officers to execute same. In case any process or pleadings mentioned in this Section are served upon the commissioner, it shall be by duplicate copies, one of which shall be filed in the office of the commissioner and another immediately forwarded by the commissioner by registered mail to the principal office of the issuer against which said process or pleadings are directed.

H. Registration of dealers and salesmen. No dealer or salesman shall engage in business in this state as such dealer or salesman or sell any securities as defined in this Section unless he has been registered as a dealer or salesman in the office of the commissioner pursuant to the provisions of this Section.

An application for registration, in writing, shall be sent by United States mail to the commissioner to be filed in the office of the commissioner in such form as the commissioner may prescribe, duly verified by oath, which shall state the principal place of business or office of the applicant, wherever situated, and the location of the principal office and all branch offices in this state, if any, the name or style of doing business, the names, residence and business addresses of all persons interested in the business as principals, co-partners, officers and directors, specifying as to each his capacity and title, the general plan and character of business and the length of time the dealer has been engaged in business. The commissioner may also require such additional information as to the applicant's previous history, record and association as he may deem necessary to establish the good repute in business of the applicant.

There shall be filed by each dealer with such application for registration, where such dealer is not domiciled in this state, an irrevocable written consent of the dealer that in all suits, proceedings or actions growing out of the violation of any provision of this Section, the service on the commissioner of any notice, process or pleading therein authorized by the laws of this state, shall be as valid and binding as if due service had been made on the dealer.The place for bringing any such action and the manner in which the written consent shall be authenticated are the same as outlined in Subsection G hereof.

If the commissioner shall find that the applicant is of good repute and has complied with the provisions of this Section, including the payment of the fee hereinafter provided, he shall register such applicant as a dealer.

Upon the written application of a registered dealer and general satisfactory showing as to good character and the payment of the proper fee, the commissioner shall register as a salesman of such dealer such natural person as the dealer may request. Such registration shall cease upon the termination of the employment of such salesman by such dealer.

The names and addresses of all persons approved for registration as dealers or salesmen and all order with respect thereto shall be recorded in a register of dealers and salesmen kept in the office of the commissioner, which shall be open to public inspection. Every registration under this Section shall expire on December 31st of each year, but new registrations for the succeeding year shall be issued upon written application and upon payment of the fee as hereinafter provided, without filing of further statements or furnishing any further information, unless specifically required by the commissioner. Applications for renewals must be made not less than thirty days nor more than sixty days before the first day of the ensuing year, otherwise they shall be treated as original applications.

The fee for such registration and for each annual renewal shall be fifty dollars in the case of dealers and ten dollars in the case of salesmen. The commissioner of insurance is authorized to withhold the funds collected under this Section to defray the expenses actually and necessarily incurred by him for salaries and expenses in carrying out the purposes of this Section.

Changes in registration occasioned by changes in the personnel of a partnership or in the principals, co-partners, officers or directors of any dealer may be made from time to time by written application setting forth the facts with respect to such change.

Any issuer of a security as defined in this Section required to be registered under the provisions of this Section, selling such securities except in exempt transactions as herein defined shall be deemed a dealer within the meaning of this Section and required to comply with all the provisions hereof.

I. Revocation of dealers' and salesmen's registration.

Registration under Subsection H hereof may be refused or any registration granted may be revoked by the commissioner if after a reasonable notice and a hearing the commissioner determines that such applicant or registrant so registered:

(1) Has violated any provision of this Section or any regulation made hereunder, or

(2) Has made a material false statement in the application for registration, or

(3) Has been guilty of a fraudulent act in connection with any sale of securities as defined in this Section, or has been or is engaged or is about to engage in making fictitious or pretended sales or purchases of any such securities or has been or is engaged or is about to engage in any practice or sale of such securities which is fraudulent or in violation of the law, or

(4) Has demonstrated his unworthiness to transact the business of dealer or salesman.

In cases of charges against a salesman notice thereof shall also be given the dealer employing such salesman.

Pending the hearing the commissioner shall have the power to order the suspension of such dealer's or salesman's registration, provided such order shall state the cause for such suspension, and provided further, that such hearing shall be held within ten days from the date of such suspension. Failure of the commissioner to hold such a hearing within such time shall constitute complete restoration of the registration of the dealer or salesman involved.

Until the entry of a final order the suspension of such dealer's registration, though binding upon the persons notified thereof, shall be deemed confidential, and shall not be published unless it shall appear that the order of suspension has been violated after notice.

In the event the commissioner determines to refuse or to revoke a registration as hereinabove provided, he shall enter a final order herein with his findings on the register of dealers and salesmen; and suspension or revocation of the registration of a dealer shall also suspend or revoke the registration of all his salesmen.

It shall be sufficient cause for refusal or cancellation of registration in case of a partnership or corporation or any unincorporated association, if any member of a partnership or any officer or director of the corporation or association has been guilty of any act or omission which would be cause for refusing or revoking the registration of an individual dealer or salesman.

J. Escrow agreement. If the statement containing information as to insurance securities which are required to be registered shall disclose that any such insurance securities shall have been or shall be intended to be issued for any organization or promotion fees or expenses, the amount and nature thereof shall be fully set forth and the commissioner may require that such insurance securities so issued in payment for organization or promotion fees or expenses shall be delivered in escrow to the commissioner or other depository satisfactory to the commissioner under an escrow agreement that the owners of such insurance securities shall not be entitled to withdraw such insurance securities from escrow until all other stockholders who have paid for their stock in cash shall have been paid a dividend or dividends aggregating not less than six per cent, shown to the satisfaction of said commissioner to have actually been earned on the investment in any stock so held, and in case of dissolution or insolvency during the time such insurance securities are held in escrow, the owners of such insurance securities shall not participate in the assets until after the owners of all other securities shall have been paid in full.

K. Injunctions. Whenever it shall appear to the commissioner, either upon complaint or otherwise, that in the issuance, sale, promotion, negotiation, advertisement or distribution of any securities as defined in this Section within this state, any person:

(1) Shall have employed or employs, or is about to employ any device, scheme or artifice to defraud or for obtaining money or property by means of any false pretense, representation or promise, or

(2) Shall have made, makes or attempts to make in this state fictitious or pretended purchases or sales of securities as defined in this Section, or

(3) Shall have engaged in or engages in or is about to engage in any practice or transaction or course of business relating to the purchase or sale of securities as defined in this Section:

(a) Which is in violation of law, or in violation of any of the rules and regulations adopted by the commissioner of insurance under this Section, or

(b) Which is fraudulent, or

(c) Which is operated, or which would operate, as a fraud upon the purchaser, any one or all of which devices, schemes, artifices, fictitious or pretended purchases or sales of securities as defined in this Section, practices, transactions and courses of business are hereby declared to be and are hereinafter referred to as fraudulent practices, or

(4) Is acting as a dealer or salesman within this state without being duly registered as such dealer or salesman as provided in this Section, the commissioner may investigate, and whenever he shall believe from evidence satisfactory to him:

(a) That any such person has engaged in, is engaged in or is about to engage in any of the practices or transactions hereinabove referred to as and declared to be fraudulent practices, or

(b) Is selling or offering for sale any securities as defined herein in violation of this Section, or is acting as a dealer or salesman without being duly registered as provided in this Section, the commissioner may, in addition to any other remedies, bring action in the name and on behalf of the state of Louisiana against such person and any other person or persons concerned in or in any way participating in or about to participate in such fraudulent practices or acting in violation of this Section, to enjoin such person and such other person or persons from continuing such fraudulent practices or engaging therein or doing any act or acts in furtherance thereof, or in violation of this Section. In any such court proceedings, the commissioner may apply for and on due showing be entitled to have issued the court's subpoena requiring forthwith the appearance of any defendant and its employees, salesmen or agents, and the production of documents, books, and records as may appear necessary for the hearing of such petition; to testify and give evidence concerning the acts or conduct or things complained of in such application for injunction. In such action, the district court of the domicile of any of the persons, firms or corporations involved, or the district court of the parish of East Baton Rouge shall have jurisdiction of the parties and the subject matter, and a judgment may be entered awarding such injunctive relief as may be proper.

L. Remedies. Every sale of securities as defined in this Section, the registration of which has been revoked or suspended by the commissioner, or made by any unregistered dealer or salesman, or by any dealer or salesman whose license has been suspended or revoked, shall be voidable at the election of the purchaser, and the person making such sale, and every director, officer or agent of or for such seller who shall have personally participated or aided in any way in the making of such sales, shall be liable in solido to such purchaser upon tender of such securities sold, or of the contract made, for the full amount paid by such purchaser with interest, all taxable court costs and a reasonable attorney's fee to be fixed by the court; provided that no such action shall be brought for the recovery of the purchase price after thirteen months from the date of such sale, or the delivery of such security to the purchaser, whichever date is latest; and provided, further, that the aforesaid interest shall be computed at the rate of six per centum per annum, less, in any case, the amount of any income from said insurance securities that may have been received by such purchaser.

M.(1) Violations; penalties. No issuer of securities as defined in this Section, or any officer, director, trustee or agent thereof, or any dealer shall sell or offer to sell any such securities without full compliance with the provisions of this Section.

Whoever violates this Subsection shall be fined not more than five thousand dollars for the first offense and not more than twenty-five thousand dollars for each subsequent offense, and the officer, director, trustee or agent thereof, or the issuer, if a natural person, may be imprisoned for not more than one year, or both.

(2) No person or corporation, whether acting on his or its own behalf, or on behalf of another, shall violate any of the provisions of this Section.

Whoever violates this Subsection shall be fined not less than one hundred dollars nor more than five hundred dollars for the first offense, and not less than five hundred dollars nor more than one thousand dollars for each subsequent offense, or imprisoned for not more than six months for the first offense, nor more than one year for each subsequent offense, or both.

(3) No dealer or salesman shall make any statement or representation not authorized by the issuer, or by a dealer registering securities under the provisions of R.S. 22:76E, or any statement or representation at variance with, or not reasonably predicated upon, statements and documents filed by the issuer or dealer in the office of the commissioner.

Whoever violates this Subsection shall be fined not more than one thousand dollars for the first offense, and not more than five thousand dollars for each subsequent offense, or imprisoned for not more than six months for the first offense and for not more than one year for each subsequent offense, or both.

(4) No person shall sign any statement, list, inventory, balance sheet or other paper or document required by any provision of this Section to be verified or sworn to, knowing any representation therein contained to be false, misleading, or untrue, and the depositing of any such statement or document in the office of the commissioner shall be deemed prima facie evidence of knowledge of the falsity thereof or of any representation therein contained, and of the wilfull signing of such statement or document.

Whoever violates this Subsection shall be guilty of perjury.

N. Statutory and civil remedies. Nothing in this Section shall limit any statutory or civil right of any person to bring action in any court for any act involved in the sale of securities as defined in this Section, or the right of this state to punish any person for any violation of any law. The attorney general and each of the district attorneys throughout this state, with regard to violations of this Section in their respective districts, shall lend full assistance to the commissioner in any investigations or prosecutions that the commissioner may deem necessary under the provisions of this Section.

O. Appeals. An appeal may be taken by any person interested from any final order of the commissioner to the district court of the parish of East Baton Rouge by filing a petition therein against the commissioner, officially as defendant, within twenty days after notice of the entry of such order and stating in said petition the grounds upon which a reversal of such final order is sought. Such petition may be accompanied by a demand upon the commissioner for a certified transcript of the record and of all papers on file in his office affecting or relating to such order, and such demand may be granted by the court and an order may be issued by the court ordering the production of a transcript of such records upon the furnishing of bond by the plaintiff, with good and sufficient security, to be approved by the court, conditioned upon the faithful prosecution of such action to final judgment and upon the payment of all costs including costs of making such transcript. Thereupon, the commissioner shall within ten days make, certify and file with the clerk of said court such a transcript, or in lieu thereof, the original papers if the court shall so order; such suit shall be given preference by the court over all matters pending in said court. The court shall receive and consider the evidence, both oral and documentary concerning the order of the commissioner objected to by the plaintiff. If the order of the commissioner shall be reversed, the court shall enter such judgment, order and decree as the equities and exigencies may require, directing the commissioner as to his further action in the matter, including the making and entering of any order or orders in connection therewith, and the conditions, limitations and restrictions to be therein contained; provided that the commissioner shall not thereby be barred from thereafter revoking or altering such order for any proper cause which may thereafter accrue or be discovered. If said order shall be affirmed, the plaintiff shall not be barred after thirty days from filing a new application, provided such new application is not otherwise barred or limited. The court shall not in any wise suspend the operation of any order of the commissioner during the pendency of the action. Mere technical irregularities in the procedure of the commissioner shall be disregarded and the burden shall rest on the plaintiff to prove his rights to a reversal of the order of the commissioner. A devolutive appeal may be taken from the judgment of the district court on the same terms and conditions as an appeal is taken in other civil actions.

P. Fees. In the event that any issue of securities as defined in this Section is not registered for any cause by the commissioner, the commissioner is hereby authorized to withhold from the application fee the sum of twenty-five dollars to defray the expense actually and necessarily incurred by him for salaries and expenses in carrying out the purposes of this Section.

In the event that the application of any dealer or salesman is for any cause not approved by the commissioner, the commissioner is hereby authorized to withhold from the application fee the sum of ten dollars in the case of a dealer and the sum of two and 50/100 dollars in the case of a salesman to defray the expenses actually necessarily incurred by him for salaries and expenses in carrying out the purposes of this Section.

Q. Construction.

Nothing in this Section shall be construed to relieve insurance companies from making reports now or hereafter required by law to be made to the commissioner, or to any other state department or agency, or from paying the fees, taxes and charges now or hereafter to be paid by insurance companies. This Section shall never be construed to repeal any law now in force regulating the organization of insurance companies in this state or the admission of any foreign insurance company, but the provisions of this Section shall be additional to any provisions otherwise regulating the business of insurance.

Acts 1958, No. 125. Amended by Acts 1958, No. 83, §§1, 3; Acts 1960, No. 164, §§1 to 3; Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996.

§77. Impairment of stock to be made good

In the event the paid-in capital stock and initial minimum surplus required of any domestic stock insurer is impaired, the commissioner of insurance shall determine the amount of such impairment and issue a written requisition to the insurer to require its stockholders to make good the amount of the impairment or deficiency within such period as he may designate, but not more than ninety days from the service of such requisition. The insurer shall call upon its stockholders ratably for such amount as is necessary to make up the impairment. If any stockholder refuses or neglects to pay the amount called for after proper notice, the insurer, through its directors, shall require the return of the certificate of stock held by such stockholder and issue to him in lieu thereof new certificates for such number of shares as he may be entitled to in proportion that the ascertained value of the assets of the corporation, as determined by the commissioner of insurance, bears to its original capital, the corporation paying for any fractional parts of shares. The directors may create new stock and issue certificates therefor and dispose of the same at not less than par for an amount sufficient to make up the original capital of the corporation. If the amount of any such impairment or deficiency cannot be made good within the time specified, the commissioner of insurance may proceed against the company in the manner provided in Part XVI of this Chapter.

Acts 1958, No. 125.

§78. Impairment removed by reduction of stock

Should the sum of the impaired paid-in capital and minimum surplus be equal to or in excess of the minimum amount of the original paid-in capital and minimum surplus, as required in R.S. 22:71, the commissioner of insurance, in lieu of demanding that the impairment be made good, may permit the reduction of the capital in the sum of the impairment. In that event, it shall be the duty of the board of directors to call in the old certificates of stock and issue new certificates of stock and issue new certificates for the number of shares which each stockholder is entitled to in the proportion that the reduced capital bears to the original capital.

Acts 1958, No. 125.

§79. Stockholders meetings

Domestic stock insurers shall hold at least one stockholders' meeting annually at a time and place specified in the articles of incorporation or by-laws of the insurer. Each stockholder shall be entitled to vote each share of stock which he holds in his own name at any and all stockholders' meetings. The right to vote any share of stock may be conferred upon another stockholder by a written proxy. Any proxy may be revoked at any time by the owner of the shares upon written notice to the secretary of the insurer or the presiding officer at any meeting.

Acts 1958, No. 125.

§80. Preferred stock

Notwithstanding any other law to the contrary, preferred stock or any other stock without voting rights may be authorized for issuance at any time in the future. Prior approval for the authorization of such stock shall be obtained from the commissioner and the commissioner shall have the right to revoke such authority for good cause. Such stock shall be fully paid at the time of issuance.

Acts 1988, No. 159, §1.

§81. Elections; officers and directors

Election of officers and directors shall be made in the manner specified in the articles of incorporation or bylaws of the insurer provided that:

(1) Each stockholder shall be entitled to one vote for each share standing in his name in the books of the corporation at the election of directors, provided policyholders may also participate in such elections to the extent authorized by the articles of incorporation of the insurer.

(2) REPEALED BY ACTS 2004, No. 525, §1.

(3) Each director, before being qualified to act, shall file with the secretary of the insurer a written acceptance of his trust.

(4) Vacancies in the board of directors are to be filled by the directors or the stockholders as the articles of incorporation or by-laws of the insurer may provide.

(5) Directors may call special meetings of the stockholders whenever they deem it proper and must call such a meeting upon the written application of the owners of one-fourth of the capital stock.

(6) The board of directors shall meet quarterly during the year and more often as may be required in the bylaws of the company.

(7) The directors shall annually elect a president, who shall be a member of the board, a secretary, and such other officers as the articles of incorporation or by-laws may provide.

Acts 1958, No. 125. Amended by Acts 1962, No. 306, §1; Acts 1978, No. 765, §1; Acts 1982, No. 248, §1; Acts 2004, No. 525, §1.

§82. Duties of officers

The president or, in his absence, the one so designated to act for him, shall preside at all meetings of the directors and of the stockholders, unless otherwise provided in the charter or bylaws.

The secretary shall keep a record of the votes and proceedings of all meetings of the directors and stockholders, a list of the stockholders, the number of shares standing in the name of each, and a record of all transfers of shares. The secretary, or other authorized officer, shall keep a record of policies issued and all authorized assignments, cancellations, and transfers thereof. He shall keep such other books and perform such other duties as the president and board of directors may require. The intentional making of any false record by the secretary or any other officer of the insurer shall be deemed an act of perjury.

Acts 1958, No. 125. Amended by Acts 1974, No. 4, §1.

§83. Citizenship required

A. Any person who is not a citizen of the United States shall not be eligible to membership on the board of directors or any office in the insurer.

B. This Section shall not apply to any insurer that is engaged in and maintains an active insurance or reinsurance business in a country other than the United States.

Acts 1958, No. 125. Amended by Acts 1977, No. 206, §1.

§84. Existing insurers: capital requirements and powers

A. Any domestic stock insurer incorporated prior to 12:00 noon of October 1, 1948 is hereby brought under all the provisions of this Code except that its capital may continue in the amount named in its articles of incorporation during the existing term thereof and it shall have such powers as it possessed prior to October 1, 1948 except as provided in Sub-section B of this Section.

B. In the event any such insurer desires to enlarge its insuring powers to incorporate additional kinds of insurance not included in its articles of incorporation as of 12:00 noon on October 1, 1948 the capital of such insurer must be increased to meet the full requirements of this Code.

C. This Section shall not apply to those insurers within the terms of R.S. 22:258 and 22:294.

Acts 1958, No. 125.

PART IV. DOMESTIC MUTUAL INSURERS

§121. Surplus requirements; applicants prior to September 1, 1989

A. Domestic mutual insurers who apply for a certificate of authority prior to September 1, 1989, may transact the following kinds of insurance in this state upon qualifying therefor and by having an initial minimum surplus represented by assets as follows:

	Insurance		Initial Minimum Surplus
(1)	Life	$	300,000
(2)	Health and accident		300,000
	(1) and (2) above		300,000
(3)	Vehicle physical damage		250,000
(4)	Title		75,000
(5)	Industrial fire		300,000
(6)	Any company organized and authorized to transact worker's compensation only as of July 27, 1966		150,000
(7)	Any company organized and authorized to transact crop and livestock insurance only as of July 27, 1966		250,000
(8)	Vehicle		1,000,000
(9)	Liability		1,000,000
(10)	Worker's compensation		1,000,000
(11)	Burglary and forgery		1,000,000
(12)	Glass		1,000,000
(13)	Fidelity and surety		1,000,000
(14)	Fire and extended coverage		1,000,000
(15)	Steam boiler and sprinkler leakage		1,000,000
(16)	Crop and livestock		1,000,000
(17)	Marine and transportation (except hull)		1,000,000
(18)	Miscellaneous		1,000,000
(19)	All insurances, except life and title		1,000,000

For the purpose of this Section, "vehicle physical damage insurance" shall be defined as insurance against loss or damage to any land vehicle or property while contained therein or thereon or being loaded or unloaded therein or therefrom.

B. Authority shall be granted mutual insurers upon compliance with all applicable requirements to transact combinations of kinds of insurance except as follows:

(1) An insurer authorized to transact life insurance shall not be authorized to transact any additional kind of insurance other than health and accident insurance.

(2) An insurer authorized to transact title insurance shall not be authorized to transact any additional kind of insurance. C. Domestic mutual insurers who apply for a certificate of authority on or after September 1, 1989, shall meet the initial minimum surplus and operating surplus requirements and other requirements of R.S. 22:121.1.

Acts 1958, No. 125. Amended by Acts 1958, No. 103, §1; Acts 1962, No. 49, §1; Acts 1966, No. 71, §1; Acts 1980, No. 471, §1; Acts 1980, 2nd Ex.Sess., No. 5, §1, eff. Sept. 15, 1980; Acts 1983, 1st Ex.Sess., No. 1, §6; Acts 1985, No. 504, §1; Acts 1989, No. 561, §1.

§121.1. Surplus requirements; applicants on and after September 1, 1989

A. Domestic mutual insurers who apply for a certificate of authority on or after September 1, 1989, may transact the following kinds of insurance in this state upon qualifying therefor and by having an initial minimum surplus and operating surplus represented by assets as follows:

	Insurance	Initial Minimum Surplus	Operating Surplus
(1)	Life	$ 2,000,000	$ 1,000,000
(2)	Health and accident	2,000,000	1,000,000
	(1) and (2) above	2,000,000	1,000,000
(3)	Vehicle physical damage	1,250,000	1,000,000
(4)	Title	500,000	500,000
(5)	Industrial fire	1,000,000	1,000,000
(6)	Vehicle	2,000,000	1,000,000
(7)	Liability	2,000,000	1,000,000
(8)	Worker's compensation	2,000,000	1,000,000
(9)	Burglary and forgery	2,000,000	1,000,000
(10)	Glass	2,000,000	1,000,000
(11)	Fidelity and surety	2,000,000	1,000,000
(12)	Fire and extended coverage	2,000,000	1,000,000
(13)	Steam boiler and sprinkler leakage	2,000,000	1,000,000
(14)	Crop and livestock	2,000,000	1,000,000
(15)	Marine and transportation (except hull)	2,000,000	1,000,000
(16)	Miscellaneous	2,000,000	1,000,000
(17)	All insurances, except life and title	2,000,000	1,000,000

B. For the purpose of this Section, "vehicle physical damage insurance" shall be defined as insurance against loss or damage to any land vehicle or property while contained therein or thereon or being loaded or unloaded therein or therefrom.

C. Authority shall be granted mutual insurers upon compliance with all applicable requirements to transact combinations of kinds of insurance except as follows:

(1) An insurer authorized to transact life insurance shall not be authorized to transact any additional kinds of insurance other than health and accident insurance.

(2) An insurer authorized to transact title insurance shall not be authorized to transact any additional kinds of insurance.

D. For the purpose of this Section, assets representing at least fifty percent of the operating surplus shall be maintained in cash or cash equivalents prescribed by the commissioner.

Acts 1989, No. 561, §1.

§121.2. Additional surplus

The commissioner may require a domestic mutual insurer to have and maintain a greater amount of surplus than prescribed in R.S. 22:121 or 121.1, based upon the type, volume, and nature of insurance business transacted. The commissioner is authorized to promulgate such rules and regulations as he may deem necessary to carry out the provisions of this Section.

Acts 1992, No. 811, §1.

§122. Hull insurance

A. For the purposes of this Section, "hull insurance" is that part of marine and transportation insurance limited to the total or partial loss of a commercial fishing vessel and any tackle, fittings, equipment, stores, boats, furniture, machinery, and appurtenances thereon due to any natural or man-made causes.

B. A nonprofit domestic mutual insurer organized to provide hull insurance, in whole or in part, is exempted from the surplus requirements listed in R.S. 22:121(A)(17). Such insurer may provide hull insurance, in whole or in part, not to exceed the amount of paid-in surplus, but in no case shall the minimum surplus be less than one hundred thousand dollars.

C. The insurer under this Section may provide hull insurance in any amount and for any coverage as the bylaws or charter of the insurer provide.

D. The insurer under this Section shall conform to all applicable provisions of this Title and all rules and regulations of the commissioner of insurance.

Acts 1985, No. 504, §1.

§123. Surplus to be paid in cash

The initial minimum surplus of any insurer shall be paid in cash within twelve months from the date of its charter and no policies shall be issued by it until the total amount required by law and specified in the charter is paid-in. A majority of the directors shall certify under oath that this requirement has been met and that the money paid-in is held as assets of the insurer to be invested as required by this Code.

Acts 1958, No. 125.

§124. Methods of acquiring surplus

The initial minimum sum required may be raised by the insurer in the following manner:

(1) By payment in advance of premiums by persons who desire to become policyholders and members of the mutual insurer. Such payments must be made in cash, and all sums so received shall be delivered in escrow to a depository satisfactory to the Commissioner of Insurance under an escrow agreement providing that the organizers or promoters of the mutual insurer shall not be entitled to withdraw such sums so deposited in escrow until sufficient initial minimum surplus shall have been raised within the prescribed period of time as provided by R.S. 22:123, and further containing a provision that in case sufficient funds have not been raised within the said prescribed period, all funds so deposited in escrow shall be refunded to the advance premium payors by the escrow agent, or

(2) The mutual insurer may borrow a sum of money sufficient to defray the reasonable expenses of its organization and to meet the requirements of R.S. 22:121 upon an agreement with the lender that the same, with interest at a rate not exceeding eight per cent per annum, shall be repaid only in the event that after such repayment with interest, the insurer shall be left possessed of sufficient assets to meet all of its liabilities and to maintain a full reserve against all its policies and to maintain the minimum surplus required by R.S. 22:121. Such agreement shall provide that the insurer shall have the option to make such payment of the loan or any part thereof whenever it shall be able to do so in accordance with the above requirements.

Acts 1958, No. 125. Amended by Acts 1962, No. 48, §1.

§125. Dividends

No domestic mutual insurer shall pay any dividends to its policyholders unless it has a surplus beyond the initial minimum surplus required and all other liabilities, except a liability created under R.S. 22:124(2), equal to fifteen per cent of such initial minimum surplus.

Acts 1958, No. 125.

§126. Impairment of surplus; how made good

Any impairment in the initial minimum surplus required of a mutual insurer may be made good by funds obtained in accordance with R.S. 22:124(2), provided the transaction is submitted to and approved by the commissioner of insurance.

Acts 1958, No. 125.

§127. Policyholders' meetings; voting rights

Domestic mutual insurers shall hold at least one policyholders' meeting annually at a time and place specified in the charter or bylaws of the insurer. Each policyholder shall be entitled to one vote on matters coming before corporate meetings of the policyholders, subject to such reasonable minimum requirements as to duration of his policy and amount of insurance held as may be made in the insurer's charter or by-laws.

The right to vote by any policyholder may be conferred upon any other policyholder by a written proxy. Any proxy may be revoked at any time by the policyholder, upon written notice to the secretary of the insurer or the presiding officer at any meeting.

Acts 1958, No. 125.

§128. Elections of officers and directors

Election of officers and directors shall be made in the manner specified in the charter or bylaws of the insurer, provided that:

(1) Each policyholder shall be entitled to one vote in accordance with the provisions of R.S. 22:127;

(2 At least a majority of the directors shall be policyholders of the insurer;

(3) Each director, before being qualified to act, shall file with the secretary of the company a written acceptance of his trust;

(4) Vacancies in the board of directors are to be filled by the directors or the policyholders as the charter or bylaws of the insurer may provide;

(5) Directors may call special meetings of the policyholders whenever they deem it proper and must call such a meeting upon the written application of the owners of one-tenth of the amount of insurance in force as of the preceding December 31 report of the insurer;

(6) The board of directors shall meet at least six times a year and oftener as may be required in the bylaws of the company;

(7) The directors shall annually elect a president, who shall be a member of the board, a secretary, and such other officers as the charter or bylaws may provide. However, the directors of a risk retention insurer to which the laws of this Part apply shall annually elect from the nonpolicy holder directors a president, a secretary, and such other officers as the charter or bylaws may provide.

Acts 1958, No. 125. Amended by Acts 1964, No. 134, §1; Acts 1989, No. 689, §1.

§129. Duties of officers

The president or, in his absence, the one so designated to act for him, shall preside at all meetings of the directors and of the policyholders, unless otherwise provided in the charter or bylaws. The secretary shall keep a record of the votes and proceedings of all meetings of the directors and policyholders. The secretary, or other authorized officer, shall keep a record of the policyholders, and of all policies issued and all authorized assignments, cancellations and transfers thereof. He shall keep such other books and perform such other duties as the president and directors may require. The intentional making of any false record by the secretary or any other officer of the insurer shall be deemed an act of perjury.

Acts 1958, No. 125. Amended by Acts 1974, No. 4, §1.

§130. Citizenship requirement

A. Any person who is not a citizen of the United States shall not be eligible for membership on the board of directors or any office in the insurer.

B. This Section shall not apply to any insurer that is engaged in and maintains an active insurance or reinsurance business in a country other than the United States.

Acts 1958, No. 125. Amended by Acts 1977, No. 206, §1.

§131. Non-assessable policies; authority to issue

Except as provided in R.S. 22:122, any domestic mutual insurer not organized under the legal reserve plan for the writing of life insurance, as defined under R.S. 22:6(1), authorized so to do by its charter may issue policies without contingent mutual liability of the policyholder for assessment upon approval of the commissioner of insurance and upon compliance with the following requirements:

(1) It shall have and at all times maintain a surplus as determined from its last annual statement, which is at least equal to the minimum capital and the paid-in surplus required on organization of a domestic stock insurer organized under the provisions of this Code.

(2) It shall have submitted a copy of its proposed non-assessable policy or policies for approval of the commissioner of insurance and shall have obtained his approval thereof.

Acts 1958, No. 125.

§132. Policyholders' liability

A. Except as to non-assessable policies, any contract of insurance issued by a mutual insurer shall provide for the contingent liability of the subscriber for payment of actual losses and expenses incurred while such contract was in force. Such contingent liability shall be in an amount as specified in the by-laws but not less than one annual premium.

B. Each assessable policy issued by the insurer shall plainly set forth a statement of the contingent liability.

C. The contingent liability of each policyholder for the obligations of a mutual insurer shall not be joint but shall be individual and several.

Acts 1958, No. 125.

§133. Domestic nonprofit mutual associations; insurer

Notwithstanding any law, regulation, or definition to the contrary, a domestic nonprofit mutual association, as defined in this Section, is deemed to be an insurer for the purposes of all surplus requirements, policy reserve requirements, and liquidation, conservation, rehabilitation, and receivership proceedings all as defined and set out in R.S. 22:1 et seq. For purposes of this Section, a domestic nonprofit mutual association shall include a domestic nonprofit mutual association which is engaged exclusively in the business of furnishing hospital service, medical, or surgical benefits, or any similar entity.

Acts 1994, 3rd Ex. Sess., No. 92, §1.

PART V. LIFE INSURERS

§161. REPEALED BY ACTS 1992, NO. 704, §2.

§162. Commissioner of insurance to make valuation

A.(1)(a) The commissioner shall annually value, or cause to be valued, the reserve liabilities, hereinafter called "reserves", for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurance company doing business in this state. The commissioner shall certify the amount of any such reserves.

(b) In calculating such reserves, the commissioner may use group methods and approximate averages for fractions of a year or otherwise.

(2)(a) Every foreign life insurance company or fraternal order shall either:

(i) Submit a valuation certificate from their domiciliary state before August first of the year following the year of valuation.

(ii) Be valued by the commissioner at the expense of the company.

(b) The commissioner shall require such documents and studies as he deems necessary in order to accomplish this valuation. In lieu of the valuation of the reserves herein required of any foreign or alien company, the commissioner may accept any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when such valuation complies with the minimum standard herein provided and if such official accepts as sufficient and for all valid legal purposes, the certificate of valuation of the commissioner when such certificate states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction.

(3) The commissioner may adopt rules and regulations to implement the provisions of this Subsection, pursuant to the Administrative Procedure Act.

B. The legal minimum standard for such valuation of policies, including industrial life insurance policies, shall be the American Experience Table of Mortality with interest at four percent per annum, except that group insurance policies under which premium rates are not guaranteed for a period in excess of five years shall be valued on the American Men Ultimate Table of Mortality with interest at three and one-half percent per annum.

C. Such valuation shall be made according to a method producing reserves not less than those produced by the one year full preliminary term method and, with respect to policies (other than industrial policies) issued to residents of the continental United States on and after January 1, 1939, not less than those produced by the modified preliminary term method under what is known as the Illinois Standard.

D. The legal minimum standard for the valuation of annuities issued on and after January 1, 1939 shall be the American Annuitants Table with interest at five percent per annum for group annuities and four percent per annum for all other annuities, except that annuities deferred ten or more years and written in connection with life insurance shall be valued on the same basis as that used in computing the consideration or premiums therefor, or upon any higher standard at the option of the insurer. Annuities issued prior to January 1, 1939, shall continue to be valued on a basis not lower than that used for the annual statement for the year 1937.

E. From and after July 29, 1947, the reserves of industrial life insurance companies and service insurance companies chartered by this state shall be determined by the commissioner of insurance by applying the following reductions to the reserve figures produced, in each case, by the method of computation set forth in the foregoing provisions of this Section:

(1) On all policies issued by such insurers prior to January 1, 1937, which provide for the furnishing of a funeral as the obligation of the insurer to the insured and his beneficiary, a reduction not to exceed seventy percent of the reserve as computed in accordance with this Part.

(2) On all policies issued by such insurers from January 1, 1937, to December 31, 1946, inclusive, which provide for the furnishing of a funeral as the obligation of the insurer to the insured and his beneficiary, a reduction not to exceed forty percent of the reserve as computed in accordance with this Part.

(3)(a) On all policies issued by such an insurer from January 1, 1947 through December 31, 1977, which provide for the furnishing of a funeral as the obligation of the insurer to the insured and his beneficiary, a reduction not to exceed twenty-five percent of the reserve as computed in accordance with this Part. However, certain policies described in R.S. 22:252 and 253 shall be fully reserved without benefit of reduction in reserves.

(b) All policies issued by such an insurer on or after January 1, 1978, which provide for the furnishing of a funeral as the obligation of the insurer to the insured and his beneficiary, shall be fully reserved without benefit of reduction in reserves.

(4) Provided, that in all cases, this reduction shall be allowed only where the insurer produces satisfactory proof of a contract with an authorized funeral director who is capable of furnishing the service specified in the policy, allowing a discount for the furnishing of the service specified therein, and in no case shall the reduction allowed herein exceed the amount of the reduction allowed in such contract.

(5) For a period of five years, beginning July 29, 1947, on all policies issued by such insurers prior to January 1, 1937, which provide in whole or in part for cash benefits as the obligation of the insurer to the insured and his beneficiary, a reduction not to exceed fifty percent of the reserve on the cash portion of the policies, as computed in accordance with Subsections A, B, C and D of this Section.

(6) Provided, further, that such reduction shall only be granted to those insurers who agree by an instrument in writing, filed with the commissioner of insurance, to apportion to and to maintain in a separate reserve fund, and who actually do apportion to and maintain in a separate fund, at least two percent of their annual gross premium income, for the purpose of bringing up the reserves to which the above reduction would apply on all funeral policies to seventy-five percent, and on all policies providing in whole or part for cash benefits to one hundred percent, of the full reserve on that portion of funeral policies providing for cash benefits, as computed in accordance with Subsections A, B, C and D of this Section, the aforesaid two percent to be in addition to any normal increase in reserves during the year.

F. Any life insurer transacting insurance in foreign countries only and not transacting insurance in any state of the United States or of the District of Columbia shall calculate its reserves on insurance written on such residents of foreign countries in accordance with reserve standards approved by the commissioner of insurance for the state of Louisiana. Acts that would otherwise be considered the transaction of insurance as that term is defined in R.S. 22:1 et seq., shall not be considered the transaction of insurance when undertaken in connection with the insurance of residents of foreign countries by life insurers that only insure residents of foreign countries. The mortality, interest, and other standards specified in this Section and in the standard nonforfeiture law as set forth in R.S. 22:168 shall not apply to policies and contracts approved for issuance only to residents of foreign countries.

Acts 1958, No. 125. Amended by Acts 1979, No. 370, §1; Acts 1992, No. 704, §1; Acts 1993, No. 535, §1; Acts 2001, No. 61, §1.

§162.1. Actuarial opinion reserves

A. Beginning December 31, 1992, each life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The commissioner by regulation shall define the specifics of this opinion and add any other items deemed to be necessary in its scope.

B.(1) Beginning December 31, 1993, each life insurance company, except as exempted by or pursuant to regulation, shall also annually include in the opinion required by Subsection A of this Section, an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the obligations of the company under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(2) The commissioner may provide by regulation for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinion required by this Section.

C. Each opinion required by Subsection B of this Section shall be governed by the following provisions:

(1) A memorandum in form and substance acceptable to the commissioner, as specified by regulation, shall be prepared to support each actuarial opinion.

(2) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified by regulation or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and to prepare such supporting memorandum as is required by the commissioner.

D. Each opinion shall be governed by the following provisions:

(1) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1992.

(2) The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by regulation.

(3) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the commissioner may by regulation prescribe.

(4) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(5) For the purposes of this Part, "qualified actuary" means a member in good standing of the American Academy of Actuaries who satisfies the requirements set forth in such regulations by the commissioner.

(6) Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

(7) Disciplinary action by the commissioner against the company or the qualified actuary shall be defined in regulations by the commissioner.

(8) Any memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection therewith, shall be kept confidential by the commissioner, and shall not be made public, and shall not be subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this Section or by regulations promulgated hereunder. However, the memorandum or other material may otherwise be released by the commissioner either with the written consent of the company or to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material. However, if any portion of the confidential memorandum is cited by the company in its marketing, is cited before any governmental agency other than a state insurance department, or is released by the company to the news media, all portions of the memorandum shall no longer be confidential.

Acts 1992, No. 704, §1.

§163. Policies under standard valuation law

A.(1) The mortality, interest, and other standards specified in R.S. 22:162 shall apply to policies and contracts issued in the United States or its territories except those issued subject to the standard non-forfeiture law as set forth in R.S. 22:168. Mortality, interest, and other standards, consistent with prevailing generally accepted actuarial assumptions at the time of issue, shall apply to policies and contracts issued outside of the United States and its territories.

(2) Reserves for all such policies and contracts may be calculated, at the option of the insurer, according to any standards which produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by R.S. 22:162.

B.(1) Except as otherwise provided in Paragraphs (2) and (3) of this Subsection, the minimum standard for the valuation of all other policies and contracts shall be the commissioner's reserve valuation methods defined in Paragraphs (4), (5), and (8) of this Subsection, five percent interest for group annuity and pure endowment contracts, four percent interest for all other such policies and contracts, and four and one-half percent interest for policies and contracts, other than annuities and pure endowment contracts, issued on or after September 7, 1979, and the following tables:

(a) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies: the Commissioners 1941 Standard Ordinary Mortality Table for such policies issued prior to the effective date of R.S. 22:168(E), the Commissioners 1958 Standard Ordinary Mortality Table for such policies issued on or after the effective date of R.S. 22:168(E) and prior to the effective date of R.S. 22:168(G); provided that for any category of such policies issued on female risks, all modified net premiums and present values referred to in this Section may be calculated according to an age not more than six years younger than the actual age of the insured; and for such policies issued on or after the effective date of R.S. 22:168(G), the Commissioners 1980 Standard Ordinary Mortality Table, or, at the election of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors, or any ordinary mortality table adopted after 1980, by the National Association of Insurance Commissioners that is approved by the commissioner.

(b) For all new industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies: the 1941 Standard Industrial Mortality Table for such policies issued prior to the effective date of R.S. 22:168(F), and for such policies issued on or after such effective date the Commissioners 1961 Standard Industrial Mortality Table or any industrial mortality table adopted after 1980, by the National Association of Insurance Commissioners that is approved by the commissioner.

(c) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies: the 1937 Standard Annuity Mortality Table or, at the option of the insurer, the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the commissioner.

(d) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies: the Group Annuity Mortality Table for 1951, any modification of such table approved by the commissioner, or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

(e) For total and permanent disability benefits in or supplementary to ordinary policies or contracts: for policies or contracts issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates adopted after 1980, by the National Association of Insurance Commissioners that are approved by the commissioner; for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either such tables or, at the option of the insurer, the Class (3) Disability Table (1926); and for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table authorized by this Part for calculating the reserves for life insurance policies.

(f) For accidental death benefits in or supplementary to policies: for policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted after 1980, by the National Association of Insurance Commissioners that is approved by the commissioner; for policies issued on or after January 1, 1961, and prior to January 1, 1966, either such table or, at the option of the insurer, the Inter-Company Double Indemnity Mortality Table; and for policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality Table. Either table shall be combined with a mortality table authorized by this Part for calculating the reserves for life insurance policies.

(g) For group life insurance, life insurance issued on the substandard basis and other special benefits: such tables as approved by the commissioner.

(2)(a) Except as provided in Paragraph (3) of this Subsection, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after September 7, 1979, and for all annuities and pure endowments purchased on or after such effective date under group annuity and pure endowment contracts shall be the Commissioner's reserve valuation methods defined in Paragraphs (4) and (5), and the following tables and interest rates:

(i) For individual annuity and pure endowment contracts issued prior to September 7, 1979, excluding any disability and accidental death benefits in such contracts: the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the commissioner, and six percent interest for single premium immediate annuity contracts, and four percent interest for all other individual annuity and pure endowment contracts.

(ii) For individual single premium immediate annuity contracts issued on or after September 7, 1979, excluding any disability and accidental death benefits in such contracts: the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980, by the National Association of Insurance Commissioners that is approved by the commissioner, or any modification of these tables approved by the commissioner, and seven and one-half percent interest.

(iii) For individual annuity and pure endowment contracts issued on or after September 7, 1979, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts: the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980, by the National Association of Insurance Commissioners that is approved by the commissioner, or any modification of these tables approved by the commissioner, and five and one-half percent interest for single premium deferred annuity and pure endowment contracts and four and one-half percent interest for all other such individual annuity and pure endowment contracts.

(iv) For all annuities and pure endowments purchased prior to September 7, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts: the 1971 Group Annuity Mortality Table, or any modification of this table approved by the commissioner, and six percent interest.

(v) For all annuities and pure endowments purchased on or after September 7, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts: the 1971 Group Annuity Mortality Table or any group annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by the commissioner, or any modification of these tables approved by the commissioner, and seven and one-half percent interest.

(b) Any insurer may file with the commissioner a written notice of its election to comply with the provisions of this Paragraph after a specified date before January 1, 1981, which shall be the effective date of this Paragraph for such insurer; provided, an insurer may elect a different effective date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer makes no such election, the effective date of this Paragraph for such insurer shall be January 1, 1981.

(3)(a) The interest rates used in determining minimum standard for the valuation of the policies and contracts listed in Subparagraphs (i), (ii), (iii), and (iv) below shall be the calendar year statutory valuation interest rates, as defined in this Paragraph, or, at the option of the insurer, for any category of policies or contracts, the rate or rates of interest provided in Paragraphs (1) or (2) of this Subsection.

(i) All life insurance policies issued in a particular calendar year, on or after the operative date of R.S. 22:168(G).

(ii) All individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1983.

(iii) All annuities and pure endowments purchased in a particular calendar year on or after January 1, 1983, under group annuity and pure endowment contracts.

(iv) The net increase, if any, in a particular calendar year after January 1, 1983, in amounts held under guaranteed interest contracts.

(b)(i) The calendar year statutory valuation interest rates shall be determined as follows and the results rounded to the nearer one-quarter of one percent:

a. For life insurance: $I = .03 + W (R1 - .03) + \frac{W}{2} (R2 - .09)$

b. For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options: $I=.03 + W (R - .03)$ where R_1 is the lesser of R and .09; R_2 is the greater of R and .09; R is the reference interest rate defined in this Paragraph; and W is the weighting factor defined in this Paragraph.

c. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in b. above, the formula for life insurance stated in a. above shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten years and the formula for single premium immediate annuities stated in b. above shall apply to annuities and guaranteed interest contracts with guarantee duration of ten years or less.

d. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in b. above shall apply.

e. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in b. above shall apply.

(ii) However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to Subparagraph differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent, the calendar year statutory valuation interest rate for such life insurance policies shall then be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying this Subparagraph, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980, by using the reference interest rate defined for 1979, and shall be determined for each subsequent calendar year regardless of when R.S. 22:168(G) becomes effective.

(iii) At the option of the insurer, calculation for life insurance policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the statutory interest rate, as defined in this Subsection, for life insurance policies issued in the immediately preceding calendar year.

(c) The weighting factors referred to in the formulae stated above shall be as provided in the following tables:

(i) Weighting factors for life insurance:

Guarantee Duration in years	Weighting Factors
10 years or less	.50
More than 10, but not more than 20 years	.45
More than 20 years	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values, or both, which are guaranteed in the original policy;

(ii) The weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options is .80.

(iii) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in (ii) above, shall be as specified in tables a., b., and c. below, according to the provisions in d., e., and f. below:

a. For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration in Years	Weighting Factor for Plan Type A	B	C
5 years or less:	.80	.60	.50
More than 5 years, but not more than 10 years:	.75	.60	.50
More than 10 years, but not more than 20 years:	.65	.50	.45
More than 20 years:	.45	.35	.35

b. Plan Type

	A	B	C
For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in (a) above increased by:	.15	.25	.05

c.

	Plan Type A	B	C
For annuities and guaranteed interest contracts valued on an issue year basis, other than those with no cash settlement options, which do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than twelve months beyond the valuation date, the factors shown in a. or derived in b. increased by:	.05	.05	.05

d. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

e. The plan type as used in the above tables is defined as follows:

Plan Type A: At any time the policyholder may withdraw funds only with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer, or without such adjustment but in installments over five years or more, or as an immediate life annuity, or no withdrawal as permitted.

Plan Type B: Before expiration of the interest rate guarantee, the policyholder may withdraw funds only with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer, or without such adjustment but in installments over five years or more, or no withdrawal is permitted. At the end of the interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years.

Plan Type C: The policyholder may withdraw funds before expiration of the interest rate guarantee in a single sum or installments over less than five years either without adjustment to reflect changes in the interest rates or asset values since receipt of the funds by the insurer, or subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

f. An insurer may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options shall be valued on an issue year basis. As used in this Paragraph, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

(d) The reference interest rate referred to in Subparagraph (b) of this Paragraph shall be defined as follows:

(i) For all life insurance, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June thirtieth of the calendar year next preceding the year of issue, of the Monthly Average of the Composite Yield on Seasoned Bonds, as published by Moody's Investors Service, Inc.

(ii) For a single premium immediate annuity and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or year of purchase, of the Monthly Average of the Composite Yield on Seasoned Bonds, as published by Moody's Investors Service, Inc.

(iii) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in (b) above with guarantee duration in excess of ten years, the lesser of the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Bonds, as published by Moody's Investors Service, Inc.

(iv) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options valued on a year of issue basis, except as stated in (ii) above, with guarantee duration of ten years or less, the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Bonds, as published by Moody's Investors Service, Inc.

(v) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Bonds as published by Moody's Investors Service, Inc.

(vi) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in (ii) above, the average over a period of twelve months, ending on June thirtieth of the calendar year of the change in the fund, of the Monthly Average of the Composite Yield on Seasoned Bonds as published by Moody's Investors Service, Inc.

(e) In the event that the Monthly Average of the Composite Yield on Seasoned Bonds is no longer published by Moody's Investors Service, Inc., or in the event that the National Association of Insurance Commissioners determines that the Monthly Average of the Composite Yield on Seasoned Bonds as published by Moody's Investors Service, Inc. is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate, which is adopted by the National Association of Insurance Commissioners and approved by the commissioner, shall be substituted.

(4)(a) Except as otherwise provided in Paragraphs (5), (6), and (8) of this Subsection, reserves according to the commissioner's reserve valuation method for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value at the date of valuation of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be the uniform percentage of the respective contract premiums, excluding extra premiums on substandard policies, for such benefits that, at the date of issue of the policy, the present value of all modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of (i) over (ii) as follows:

(i) A net level annual premium equal to the present value at the date of issue of such benefits provided for after the first policy year, divided by the present value at the date of issue of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided however, that such net level annual premium shall not exceed the net level annual premium on the nineteen year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such policy.

(ii) A net one year term premium for such benefits provided for in the first policy year.

(b) Any life insurance policy issued on or after January 1, 1986, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value, or a combination thereof, in an amount greater than such excess premium, the reserve according to the Commissioner's reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in Paragraph (8), be the greater of the reserve as of such policy anniversary calculated as described in the preceding paragraph and the reserve as of such policy anniversary calculated as described in said Paragraph, but with the value defined in Subparagraph (a) above being reduced by fifteen percent of the amount of such excess first year premium, all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, the policy being assumed to mature on such date as an endowment, and the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in Paragraphs (1) and (3) of this Subsection shall be used.

(c) Reserves according to the Commissioner's reserve valuation method for life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums shall be calculated by a method consistent with the principles of this Paragraph. Reserves for group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended; disability and accidental death benefits in all policies and contracts; and all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the benefits granted and approved by the commissioner

(5)(a) This Section shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended.

(b) Reserves according to the commissioner's annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

(6)(a) An insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, shall in no event be less than the aggregate reserves calculated in accordance with the methods set forth in Paragraphs (4), (5), (8), and (10) and the mortality table or tables, and rate or rates of interest used in calculating nonforfeiture benefits for such policies.

(b) In no event shall the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined to be necessary to render the opinion required in R.S. 22:162.1.

(c) The commissioner of insurance shall promulgate a regulation containing the minimum standards applicable to the valuation of health and accident plans.

(7) Reserves for any category of policies, contracts, or benefits may be calculated at the option of the insurer according to any standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be higher but may be lower than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for therein.

(8)(a) If in any contract year the gross premium charged by any life insurer on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this Paragraph are those standards stated in Paragraphs (1) and (3) of this Subsection.

(b) Any life insurance policy issued on or after January 1, 1986, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this Paragraph (8) shall be applied as if the method actually used in calculating the reserve for such policy were the method described in Paragraph (4), ignoring the Subparagraph (b) of Paragraph (4). The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with Paragraph (4), including Subparagraph (b) of that Paragraph, and the minimum reserve calculated in accordance with this Paragraph (8).

(9) Nothing in this Subsection B shall apply to any policy issued by any insurer subject to the provisions of Parts VII or VIII of this Chapter, unless such insurer elects to comply with the standard non-forfeiture law.

(10) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in Paragraphs (4), (5), and (8), the reserves which are held under any such plan shall be appropriate in relation to the benefits and the pattern of premiums for that plan, and shall be computed by a method which is consistent with the principles of this Section as determined by the commissioner.

C. Any such insurer which at any time shall have adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard herein provided may, with the approval of the commissioner of insurance, adopt any lower standard of valuation, but not lower than the minimum herein. However, for the purposes of this Section, the holding of additional reserves previously determined by a qualified actuary to be necessary to render the opinion required by the Part shall not be deemed to be the adoption of a higher standard of valuation.

Acts 1958, No. 125. Amended by Acts 1960, No. 285, §1; Acts 1964, No. 154, §1; Acts 1974, No. 4, §1; Acts 1975, No. 261, §1; Acts 1979, No. 370, §2; Acts 1982, No. 464, §1; Acts 1992, No. 704, §1; Acts 2003, No. 171, §1.

§164. Dividends; payments limited when reserve deficient

Payments in the form of dividends or otherwise shall not be made to its stockholders by any domestic life insurer, unless its assets exceed, to the amount of such payment, the amount of its paid-up capital stock and all its liabilities, including its reinsurance reserves, computed upon a basis hereinabove provided, and no payments shall be made to the policyholders of any such insurer, except for matured claims, and in the purchase of surrendered policies, unless its assets exceed to the amount of such payments, its liabilities, including its reinsurance reserves, computed as hereinabove provided.

Provided that, in the case of any insurer availing itself of the reduction in the reserves allowed in R.S. 22:162 on funeral or cash policies, no payments shall be made to its stockholders in the form of dividends or otherwise, unless and until the reserve is equal to seventy-five per cent on funeral policies and one hundred per cent on the cash policies and that portion of combination policies providing for cash benefits, of the full reserve as computed in accordance with Sub-sections A, B, C, and D of R.S. 22:162.

Acts 1958, No. 125.

§165. Penalty; improper payment of dividends

Any officer or director of any insurer who votes or assents to any payment, either to stockholders or policyholders, in violation of any of the provisions of R.S. 22:164 shall forfeit to the state the sum of five thousand dollars, to be recovered in an action brought in the name of the commissioner of insurance.

Acts 1958, No. 125.

§166. Policies to contain non-forfeiture benefits

Every contract or policy of life or endowment insurance (other than a term policy for 20 years or less and policies of $1,250.00 or less issued as industrial policies under the provisions of R.S. 22:256) issued on the life of a resident of this state or delivered within this state by any insurer, after January 1, 1937, unless the company elects to take advantage of the option provided in R.S. 22:168(H), shall contain a stipulation that after three full annual premiums have been paid thereon it shall not lapse or become void or be forfeited for non-payment of any premium thereafter, or of any note therefor, or of any loan on such policy, or of any interest on such note or loan, except as provided in R.S. 22:167.

Acts 1958, No. 125. Amended by Acts 1958, No. 90, §1, eff. Jan. 1, 1959 at 12:00 Noon.

§167. Paid-up, extended insurance and cash value

No such policy of life or endowment insurance (other than a term policy for twenty years or less and policies of industrial insurance pursuant to the provisions of R.S. 22:256) issued by any legal reserve life insurer on or after January 1, 1907, unless the company elects to take advantage of the option provided in R.S. 22:168(H), after being in force three full years shall by its terms lapse or become forfeited by the nonpayment of any premium, or any note therefor, or of any loan on such policy, or of any interest on such note or loan. The reserve on such policy computed according to the standard adopted by said insurer, together with the value of any dividend additions upon said policy after deducting any indebtedness to the company and after deducting one-fifth of the said entire reserve or the sum of two and fifty-one hundredths dollars for each one hundred dollars of the face of said policy if said sum shall be more than the said one-fifth, shall upon demand, with surrender of the policy, be applied as a surrender value as agreed upon in the policy; provided that, if no other option expressed in the policy be availed of by the owner thereof, the policy shall provide for said value to be applied to the automatic option shown in the policy which automatic option shall be one of the following, either to purchase upon the same life, at the attained age, paid-up insurance, payable at the same time, and under the same conditions, except as to the payment of premiums, as the original policy, or to continue the insurance in force at its full amount, including any outstanding dividend additions, less any outstanding indebtedness on the policy, so long as such surrender value will purchase nonparticipating temporary insurance at net single premium rates by the standard adopted by the insurer, at the age of the insured at the time of lapse or forfeiture, provided that in case of any endowment policy, if the sum applicable to the purchase of temporary insurance be more than sufficient to continue the insurance to the end of the endowment term named in the policy, the excess shall be used to purchase, in the same manner, pure endowment insurance payable at the end of the endowment term named in the policy on the conditions on which the original policy was issued; and provided further that, in calculating the net single premium for any temporary insurance, the insurer may use one hundred thirty percent of the rate of mortality adopted as a basis for reserve for the policy. This further provision shall not apply to any mortality table constructed on the basis of insurance companies experience prior to 1900. Provided, further, that any attempted waiver of the provisions of this paragraph in any application, policy or otherwise shall be void, and that any value allowed in lieu thereof shall be at least equal to the net value of temporary insurance or of the temporary and pure endowment insurance herein provided for. The term of temporary insurance herein provided for shall include the period of grace, if any.

Acts 1958, No. 125. Amended by Acts 1958, No. 91, §1, eff. Jan. 1, 1959 at 12:00 Noon; Acts 1974, No. 4, §1.

§168. Standard nonforfeiture law for life insurance

A.(1) This Section shall be known as the "Standard Nonforfeiture Law for Life Insurance". In the case of policies issued on and after the effective date of this Section, as defined in Subsection L hereof, no policy of life insurance, except as stated in Subsection K shall be delivered or issued for delivery in this state unless it shall contain in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements hereinafter specified and are essentially in compliance with Subsection J of this Section:

(a) That, after premiums have been paid for more than one year, in the event of default in any premium payment, the insurer will grant, upon proper request not later than sixty days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such amount as may be hereinafter specified. In lieu of such stipulated paid-up nonforfeiture benefit, the insurer may substitute, upon proper request not later than sixty days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

(b) That, upon surrender of the policy within sixty days after the due date of any premium payment in default after premiums have been paid for at least three full years in the case of ordinary insurance or five full years in the case of industrial insurance, the insurer shall pay in lieu of any paid-up nonforfeiture benefit a cash surrender value of such amount as may be hereinafter specified.

(c) That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than sixty days after the due date of the premium in default.

(d) That if the policy shall have become paid-up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the insurer will pay upon surrender of the policy within thirty days after any policy anniversary a cash surrender value of such amount as may be hereinafter specified.

(e) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first twenty policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the insurer on the policy.

(f) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.

(2)(a) Any of the foregoing provisions, or portions thereof, not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

(b) Notwithstanding any other provisions to the contrary, the insurer shall reserve the right to defer the payment of any cash surrender value for a period not to exceed six months after demand therefor with surrender of the policy. Notwithstanding the above provision, if payment is not made within thirty days after demand therefor with surrender of the policy, the insurer shall pay, in addition to the cash surrender value, interest on the cash surrender value at the judicial interest rate set by Louisiana Civil Code Article 2924 commencing from the date of surrender until the cash surrender value is paid in full within the six-month period.

B.(1) Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by Subsection A, shall be an amount not less than the excess, if any, of the present value on such anniversary of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of the then present value of the adjusted premiums as defined in Subsections D, E, F, and G of this Section corresponding to premiums which would have fallen due on and after such anniversary, and the amount of any indebtedness to the insurer on the policy.

(2) Provided, however, that for any policy issued on or after the effective date of Subsection G of this Section as defined therein, which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in the first paragraph of this Subsection shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in such paragraph for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision.

(3) Provided, further, that for any family policy issued on or after the effective date of Subsection G of this Section as defined therein, which defines a primary insured and provides term insurance on the life of the spouse of the primary, insured expiring before the spouse's age seventy-one, the cash surrender value referred to in the first paragraph of this Subsection shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in such paragraph for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse.

(4) Any cash surrender value available within thirty days after any policy anniversary under any policy paid-up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by Subsection A, shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the insurer on the policy.

C. Any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy, or, if none is provided for, that cash surrender value which would have been required by this Section in the absence of the condition that premiums shall have been paid for at least a specified period.

D.(1) This Subsection shall not apply to policies issued on or after the effective date of Subsection G as defined therein. Except as provided in the third paragraph of this Subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding extra premiums on substandard policies, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of (a) the then present value of the future guaranteed benefits provided for by the policy; (b) two percent of the amount of insurance, if the insurance be uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy; (c) forty percent of the adjusted premium for the first policy year; and (d) twenty-five percent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less. In applying the percentages specified in (c) and (d) above, no adjusted premium shall be deemed to exceed four percent of the amount of insurance or uniform amount equivalent thereto. The date of issue of a policy for the purpose of this Subsection shall be the date from which the first policy anniversary is computed.

(2) In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount thereof for the purpose of this Subsection shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy. Provided, however, that in the case of a policy providing a varying amount of insurance issued on the life of a child under age ten, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten were the amount provided by such policy at age ten.

(3) Whenever a term benefit is added as a rider or as a supplemental policy provision, the adjusted premiums for such added benefit may be calculated as though it were separate and independent from the policy. In all other respects the term benefit shall conform to the provisions of this Section.

(4) Except as otherwise provided in Subsections E and F, all adjusted premiums and present values referred to in this Section shall for all policies of ordinary insurance be calculated on the basis of the Commissioners 1941 Standard Ordinary Mortality Table; provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than three years younger than the actual age of the insured and such calculations for all policies of industrial insurance, as defined in R.S. 22:251, shall be made on the basis of the 1941 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest, not exceeding three and one-half percent per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than one hundred and thirty percent of the rates of mortality according to such applicable table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the commissioner.

E.(1) This Subsection shall not apply to ordinary policies issued on or after the effective date of Subsection G as defined therein. In the case of ordinary policies issued on or after the effective date of this Subsection as defined herein and in Subsection L, all adjusted premiums and present values referred to in this Section shall be calculated on the basis of the Commissioner's 1958 Standard Ordinary Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits provided that such rate of interest shall not exceed four percent per annum for policies issued prior to September 7, 1979, and such rate of interest shall not exceed five and one-half percent per annum for policies issued on or after September 7, 1979, and provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioner's 1958 Extended Term Insurance Table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the commissioner.

(2) Any insurer may file with the commissioner a written notice of its election to comply with the provisions of this Subsection after a specified date with respect to the policies specified in the notice. After the filing of such notice, then upon such specified date which shall be the effective date of this Subsection for such insurer with respect to such policies, this Subsection shall become effective with respect to such policies specified in such notice and thereafter issued by such insurer.

F.(1) This Subsection shall not apply to industrial policies issued on or after the effective date of Subsection G as defined therein. In the case of industrial policies issued on or after the effective date of Subsection F as defined herein and in Subsection L, all adjusted premiums and present values referred to in this Section shall be calculated on the basis of the Commissioner's 1961 Standard Industrial Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits, but such rate of interest shall not exceed four percent per annum for policies issued prior to September 7, 1979, and such a rate of interest shall not exceed five and one-half percent per annum for policies issued on or after September 7, 1979. In addition, in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioner's 1961 Industrial Extended Term Insurance Table. Further, for insurance issued on a substandard basis, the calculations of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the commissioner.

(2) After September 7, 1979, any insurer may file with the commissioner a written notice of its election to comply with the provisions of this Subsection after a specified date with respect to the policies specified in the notice. After the filing of such notice, then upon such specified date, which shall be the effective date of the Subsection for such insurer with respect to such policies, this Subsection shall become effective with respect to the industrial policies specified in such notice and thereafter issued by such insurer.

G.(1) This Subsection shall apply to all policies issued on or after the effective date of this Subsection as defined herein. Except as provided in Paragraph (7) of this Subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of the following three factors: (a) the then present value of the future guaranteed benefits provided for by the policy; (b) one percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; (c) one hundred twenty-five percent of the nonforfeiture net level premium as hereinafter defined. Provided, however, that in applying the percentage specified in (c) above no nonforfeiture net level premium shall be deemed to exceed four percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this Subsection shall be the date as of which the rated age of the insured is determined.

(2) The nonforfeiture net level premium shall be equal to the present value at the date of issue of the policy of the guaranteed benefits provided for by the policy divided by the present value at the date of issue of the policy of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.

(3) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not vary from those stipulated by the policy immediately after the change.

(4) Except as otherwise provided in Paragraph 7 of this Subsection, the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums of all such future adjusted premiums shall be equal to the excess of (A) the sum of (a) the then present value of the then future guaranteed benefits provided for by the policy and (b) the additional expense allowance, if any, over (B) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(5) The additional expense allowance at the time of the change to the newly defined benefits or premiums shall be the sum of (a) one percent of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and (b) one hundred twenty-five percent of the increase, if positive, in the nonforfeiture net level premium.

(6) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (A) by (B) where (A) equals the sum of: (a) the nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred, and (b) the present value of the increase in future guaranteed benefits provided for by the policy; and (B) equals the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(7) Notwithstanding any other provisions of this Subsection to the contrary in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if the substandard policy were issued to provide such higher uniform amounts of insurance on the standard basis.

(8) All adjusted premiums and present values referred to in this Section shall be calculated for all policies of ordinary insurance on the basis of the Commissioner's 1980 Standard Ordinary Mortality Table or at the election of the insurer for any one or more specified plans of life insurance, the Commissioner's 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; shall be calculated for all policies of industrial insurance on the basis of the Commissioner's 1961 Standard Industrial Mortality Table; and shall be calculated for all policies issued in a particular calendar year on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this Subsection for policies issued in that calendar year. Provided, however, that:

(a) At the option of the insurer, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this Subsection, for policies issued in the immediately preceding calendar year.

(b) Under any paid-up nonforfeiture benefit including any paid-up dividend additions, any cash surrender value available, whether or not required by Subsection A, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any.

(c) An insurer may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

(d) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioner's 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioner's 1961 Industrial Extended Term Insurance Table for policies of industrial insurance.

(e) For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables. (f) Any ordinary mortality tables, adopted after 1980, by the National Association of Insurance Commissioners that are approved by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioner's 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioner's 1980 Extended Term Insurance Table.

(g) Any industrial mortality tables adopted after 1980, by the National Association of Insurance Commissioners that are approved by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioner's 1961 Standard Industrial Mortality Table or the Commissioner's 1961 Industrial Extended Term Insurance Table.

(9) The nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred and twenty-five percent of the interest rate used in determining the minimum standard for the valuation of such policy as defined in the R.S. 22:163, rounded to the nearer one quarter of one percent.

(10) Notwithstanding any other provision in this Code to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

(11) After the effective date of this Subsection, any insurer may file with the commissioner a written notice of its election to comply with the provisions of this Section after a specified date before January 1, 1989, which shall be the effective date of this Subsection for such insurer. If an insurer makes no such election, the effective date of this Subsection for such insurer shall be January 1, 1989.

H. In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in Subsections A, B, C, D, E, F, or G herein, then the commissioner shall be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by Subsections A, B, C, D, E, F, or G herein. The commissioner shall be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds. The cash surrender values and paid-up nonforfeiture benefits provided by such plan shall not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this Section as determined by the commissioner.

I.(1) Any cash surrender value and any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in Subsections B, C, D, E, F, and G may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall not be less than the amounts used to provide such additions. Notwithstanding the provisions of Subsection B, additional benefits payable in any of the following shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this Section:

(a) In the event of death or dismemberment by accident or accidental means;

(b) In the event of total and permanent disability;

(c) As reversionary annuity or deferred reversionary annuity benefits;

(d) As term insurance benefits, whether or not provided by a rider or supplemental policy provision to which, if issued as a separate policy, this Section shall not apply;

(e) As term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six, is uniform in amount after the child's age is one, and has not become paid-up by reason of the death of a parent of the child; and

(f) As other policy benefits additional to life insurance and endowment benefits and premiums for all such additional benefits.

(2) No such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

J.(1) This Subsection in addition to all other applicable Subsections of this Section shall apply to all policies issued on or after January 1, 1986. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than two-tenths of one percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years, from the sum of: (a) the greater of zero and the basic cash value hereinafter specified and (b) the present value of any existing paid-up additions less the amount of any indebtedness to the insurer under the policy.

(2) The basic cash value shall be equal to the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the insurer, if there had been no default, less the then present value of the nonforfeiture factors, as hereinafter defined, corresponding to premiums which would have fallen due on and after such anniversary. Provided, however, that the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in Subsection B or Subsection D, whichever is applicable, shall be the same as are the effects specified in Subsection B or Subsection D, whichever is applicable on the cash surrender values defined in that Subsection.

(3) The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in Subsection D or Subsection G, whichever is applicable. Except as is required by the next succeeding sentence of this Paragraph, such percentage shall be the same percentage for each policy year between the second policy anniversary and the later of the fifth policy anniversary and that of the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two tenths of one percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. No percentage after the later of the two policy anniversaries specified in the preceding sentence shall apply to fewer than five consecutive policy years. Provided, that no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in Subsections D or G, whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

(4) All adjusted premiums and present values referred to in this Subsection shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other subsections of this Section.

(5) Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in Subsections A, B, C, G, and I. The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed as items (a) through (f) in Subsection I shall conform with the principles of this Subsection.

(6) The cash surrender values referred to in this Subsection shall include any endowment benefits provided for by the policy.

K.(1) This Section shall not apply to any of the following:

(a) Reinsurance.

(b) Group insurance.

(c) Pure endowment.

(d) Annuity or reversionary annuity contract.

(e) Term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy.

(f) Term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits on which each adjusted premium calculated as specified in Subsections D, E, F, and G, is less than the adjusted premium so calculated, on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy.

(g) Policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in Subsections B, C, D, E, F, and G, exceeds two and one-half percent of the amount of insurance at the beginning of the same policy year.

(h) Policy which shall be delivered outside this state through an agent or other representative of the insurer issuing the policy.

(i) Policy on the life of an individual residing outside of the continental United States.

(j) Policy issued in accordance with Parts VII or VIII, unless the insurer issuing such policy elects to comply with the provisions of this Section.

(2) For purposes of determining the applicability of this Section, the age at expiry for a joint term life insurance policy shall be the age at expiry of the oldest life.

L. Any insurer may, at its option, file with the commissioner of insurance a written notice of its election to comply with the provisions of this Section after a specified date with respect to the policies specified in the notice. After the filing of such notice, then upon such specified date, which shall be the effective date for such insurer with respect to such policies, this Section shall become operative with respect to the policies specified in such notice and thereafter issued by such insurer. The insurer may issue participating and nonparticipating policies under the same plan of insurance and either or both, at its option, subject to the provisions of R.S. 22:167.

Acts 1958, No. 125. Amended by Acts 1958, No. 92, §1, eff. Jan. 1, 1959 at 12:00 Noon; Acts 1960, No. 286, §1; Acts 1964, No. 155, §1; Acts 1974, No. 4, §1; Acts 1975, No. 261, §2; Acts 1979, No. 370, §3; Acts 1982, No. 464, §1; Acts 1991, No. 951, §1.

§169. Automatic premium loans

Nothing in R.S. 22:167 or 22:168 shall be construed to prohibit any insurer from including in its policies a provision for automatic premium loans to prevent default in the payment of premiums. No such provision shall be effective in any policy delivered or issued for delivery in this state unless requested in writing by the applicant or insured.

Acts 1958, No. 125.

§170. Life insurance policies; standard provisions

A. No policy of life insurance, except as stated in Subsection C, shall be delivered or issued for delivery in this state unless it contains in substance the following provision or provisions which, in the opinion of the commissioner of insurance, are more favorable to the policyholder:

(1) A provision that the insured is entitled to a grace period either of thirty days or, at the option of the insurer, of one month within which the payment of any premium after the first may be made, during which period of grace the policy shall continue in full force, but if a claim arises under the policy during such period of grace before the overdue premiums or the deferred premiums of the current policy year, if any, are paid, the amount of such premiums, together with interest, not in excess of six per cent per annum, on any overdue premium, may be deducted from any amount payable under the policy in settlement.

(2) A provision that the policy shall be incontestable after it has been in force during the lifetime of the insured for a period of two years from its date of issue, except for non-payment of premiums and except for the conditions of the policy relating to military or naval service, or services auxiliary thereto; and at the option of the insurer, provisions relating to benefits in the event of disability, as defined in the policy, and provisions which grant additional insurance specifically against death by accident or accidental means, may also be excepted.

(3) A provision that the policy shall constitute the entire contract between the parties, or if a copy of the application is endorsed upon or attached to the policy when issued, a provision that the policy and the application therefor shall constitute the entire contract between the parties.

(4) A provision that if the age of the person insured or the age of any other person whose age is considered in determining the premiums has been misstated, any amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age, or ages.

(5) A provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the policy.

(6) A provision in accordance with R.S. 22:166 through 22:168 specifying the options, if any, available under the policy in the event of default in a premium payment. Provided, however, the mortality table and rate of interest used as a basis for the calculation of such options shall be designated by the policy.

(7) A provision that when the policy has a loan value, the insurer issuing it shall advance at the option of the person entitled thereto, a sum equal to or less than the cash surrender value of the policy at the end of the current policy year computed in accordance with the provisions of this Part, at any time while the policy is in force, on proper assignment or pledge of the policy or with the policy as security at a specified rate of interest not exceeding eight per centum per annum on policy contracts in effect prior to September 10, 1982, or in accordance with the provisions of R.S. 22:170.1 on policy contracts in effect on or after September 10, 1982. The interest shall be compounded annually payable in advance. The policy shall also contain a provision that the insurer may deduct from such loan value, in addition to the indebtedness deducted in determining such value, any unpaid balance of the premium for the current policy year. The policy shall also contain a provision that, if the loan is made or repaid on a date other than the anniversary of the policy, the insurer may collect interest for the portion of the current policy year on a pro rata basis at the rate of interest specified in the policy. The policy may further provide that interest on the loan may be compounded annually and, if not paid when due, it shall be added to the existing loan and shall bear interest at the same rate. The policy may further provide that, if and when the total indebtedness on the policy, including interest due or accrued, equals or exceeds the amount of the loan value thereof at such time, and if at least thirty days prior notice has been given in the manner provided in R.S. 22:177, then the policy shall terminate and become void. The insurer may provide in the policy that the making of any such loan, except when made to pay premiums, may be deferred for a period not to exceed six months after the application therefor has been received by it. The provision shall not apply to term policies of twenty years or less.

(8) A provision specifying the basis used in determining non-forfeiture benefits. In case the proceeds of the policy are payable in installments or as an annuity, a table showing the amounts of the installments or annuity payments.

(9) A provision that the policy will be reinstated at any time within three years from the date of default, unless the cash surrender value has been exhausted by payment or unless the period of extended insurance has expired, upon the application of the insured and the production of evidence of insurability, including good health, satisfactory to the insurer and the payment of all overdue premiums and the payment or reinstatement of any other indebtedness to the insurer upon said policy with the interest at a rate not exceeding six per centum per annum compounded annually.

(10)(a) A provision, prominently printed on the life insurance policy or attached thereto, notifying the insured that ten days are allowed, from the date of his receipt of the policy, to examine its provisions. If the policy is not as explained by the company, its representative, or as understood by the insured, the policy may be surrendered within said ten-day period, and any premium advanced by the insured, upon the surrender, shall be immediately returned to him. The insurer shall have the option of printing, attaching, or endorsing the notice above required or a notice of equal prominence which, in the opinion of the commissioner of insurance, is not less favorable to the policyholder. This Paragraph shall not apply to trip-travel insurance policies which by their terms are not renewable.

(b) If the policy is delivered by an agent or broker, a receipt shall be signed by the policyholder acknowledging delivery of the policy. The receipt shall contain the policy number and the date the delivery was completed. All delivery receipts required by this Subparagraph shall be retained by the insurer or its agent or the broker for two consecutive years. The requirement of this Subparagraph shall not apply to any insurer that markets policies under a home service marketing distribution method and that issues a majority of its policies on a weekly or monthly basis.

(c) If the policy is delivered by mail, it shall be sent by certified mail, return receipt requested, or a certificate of mailing shall be obtained showing the date the policy was mailed to the policyowner. For policy issuances verified by a certificate of mailing, it is presumed that the policy is received by the policyowner ten days from the date of mailing. The receipts and the certificate of mailing described in this Section shall be retained by the insurer or agent for three years.

B. No policy of life insurance delivered or issued for delivery in this state shall contain any provision which excludes or restricts liability for death caused in a certain specified manner or occurring while the insured has a specified status, except the following provisions, or provisions which in the opinion of the commissioner of insurance are substantially the same or more favorable to policyholders:

Provisions excluding or restricting coverage in the event of death occurring:

(1) As a result of war declared or undeclared under conditions specified in the policy.

(2) While in (a) the military, naval or air forces of any country at war, declared or undeclared, or (b) any ambulance, medical, hospital or civilian noncombatant unit serving with such forces, either while serving with or within six months after termination of service in such forces or units.

(3) As a result of self-destruction while sane or insane within two years from the date of issue of the policy.

(4) As a result of aviation under conditions specified in the policy.

(5) Within two years from the date of issue of the policy as a result of a specified hazardous occupation or occupations, or while the insured is residing in a specified foreign country or countries.

In the event of death as to which there is an exclusion or restriction pursuant to Paragraphs (1), (3), (4), or (5) of this Subsection, the insurer shall pay an amount not less than the reserve on the face amount of the policy, together with the reserve for any paid-up additions thereto, and any dividends standing to the credit of the policy, less any indebtedness to insurer on the policy, including interest due or accrued.

In the event of death as to which there is an exclusion or restriction pursuant to Paragraph (2) of this Subsection, the insurer shall pay the greater of (a) the amount specified in the preceding paragraph or (b) the amount of the gross premiums charged on the policy less dividends paid in cash or used in the payment of premiums thereon and less any indebtedness to the insurer on the policy, including interest due or accrued.

A clause in any policy of life insurance, issued under this Code, providing that such policy shall be incontestable after a specified period shall preclude only a contest of the validity of the policy, and shall not preclude the assertion at any time of defenses based upon provisions which exclude or restrict coverage as provided in this Subsection, whether or not such restrictions or exclusions are excepted in such clause; nor upon a provision regarding misstatement of age as provided in Paragraph (4) of Subsection A of this Section, whether or not such provision is excepted in such clause.

Nothing contained herein shall apply to any provision in a life insurance policy for additional benefits in the event of death by accident or accidental means.

C. Any of the foregoing provisions or portions thereof not applicable to single premium or non-participating or term policies, shall to that extent not be incorporated therein. The provisions of this Section shall not apply to policies of industrial life insurance, service insurance, or to policies of group life insurance.

D. Every life insurance policy delivered or issued for delivery in this state, other than policies of industrial life insurance or service insurance, shall allow election by the beneficiary of an option to receive benefits in the form of a lump sum payment.

Acts 1958, No. 125. Amended by Acts 1960, No. 169, §1; Acts 1966, No. 169, §1; Acts 1975, No. 261, §3; Acts 1981, No. 661, §1; Acts 1982, No. 465, §1; Acts 1993, No. 141, §1; Acts 2003, No. 125, §1.

§170.1. Maximum rate of interest on policy loans

A. Each life insurance policy contract entered into on or after September 10, 1982, which provides for policy loans shall contain a provision concerning maximum policy loan interest rates as follows:

(1) A provision permitting a maximum interest rate of not more than twelve percent per annum; or

(2) A provision permitting an adjustable maximum interest rate established in accordance with this Section.

B. The rate of interest charged on a policy loan made under Paragraph (2) of Subsection A of this Section shall not exceed the higher of the following:

(1) The published monthly average for the calendar month ending two months prior to the date on which the rate is determined; or

(2) The rate used to compute the cash surrender values under the policy during the applicable period plus one percent per annum.

C. If the adjustable maximum rate of interest provided in Paragraph (2) of Subsection A of this Section is used, the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy. D. The maximum rate for each policy referred to in Paragraph (2) of Subsection A of this Section shall be determined at regular intervals at least once every twelve months, but not more frequently than once in any three month period. At the intervals specified in the policy:

(1) The interest rate being charged may be increased whenever such increase, as determined under Subsection B of this Section, would increase that rate by one-half of one percent or more per annum.

(2) The rate being charged shall be reduced whenever such reduction, as determined under Subsection B of this Section, would decrease that rate by one-half of one percent of more per annum.

E. The insurer shall, at the time a cash loan is made, notify the policyholder of the initial rate of interest on the loan, and shall notify the policyholder of the initial rate of interest on the premium loan as soon as it is reasonably practical to do so after making the initial loan. Such notice need not be given to the policyholder when a further premium loan is added except as provided below. The insurer shall send reasonable advance notice of any increase in the rate to policyholders with loans, and include in the notices required above, the substance of the pertinent provisions of Subsections A and C of this Section.

F. The loan value of the policy shall be determined in accordance with R.S. 22:168 or R.S. 22:173.1, but no policy shall terminate in a policy year as the sole result of change in the interest rate during that policy year, and the insurer shall maintain coverage during that policy year until the time at which it would otherwise have terminated if there had been no change during that policy year.

G. For purposes of this Section:

(1) The term "rate of interest on policy loans" used in this Section shall include the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy.

(2) The term "policy loan" shall include any premium loan made under a policy to pay one or more premiums that were not paid to the insurer as they became due.

(3) The term "policyholder" shall include the owner of the policy or the person designated to pay premiums as shown on the records of the insurer.

(4) The term "policy" shall include certificates issued by a fraternal benefit society and annuity contracts which provide for policy loans.

(5) The term "published monthly average" shall mean Moody's Corporate Bond Yield Average--Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto. In the event that Moody's Corporate Bond Yield Average--Monthly Average Corporates is no longer published, the commissioner of insurance shall establish by regulation a substantially similar average.

H. No other provision of law shall apply to policy loan interest rates unless made specifically applicable to such rates.

Added by Acts 1982, No. 465, §1.

§171. Ante-dating of life insurance policies prohibited

No insurer shall knowingly deliver or issue for delivery in this state any policy or contract of life insurance which purports to be issued or to take effect as of a date more than six months before the application therefor was made, if thereby the premium on such policy or contract is reduced below the premium which would be payable thereon as determined by the nearest birthday of the insured at the time when such application was made. No agent or other representative of an insurer shall in this state prepare, submit or accept any application for life insurance which bears a date earlier than the date when such application was made by the insured or applicant, if thereby the premium on such policy is reduced as above stated. Nothing contained in this Section shall invalidate any contract made in violation of this Section. This Section shall not be construed to prohibit the exchange, alteration or conversion of policies of life insurance as of the original date of such policies if the amount of insurance provided under the new policy does not exceed the amount of insurance under the original policy or the amount of insurance which the premium paid for the original policy would have purchased if the new policy had been originally applied for, whichever is greater; nor to prohibit the exercise of any conversion privilege contained in any policy or contract.

Acts 1958, No. 125.

§172. Incontestability after reinstatement

The reinstatement of any policy of life or noncancellable disability insurance or contract of annuity delivered or issued for delivery in this state after 12:00 noon of October 1, 1948 shall be incontestable after the same period following reinstatement and with the same conditions and exceptions, as provided in the policy or contract with respect to the incontestability thereof.

Acts 1958, No. 125.

§173. Annuities and pure endowment contracts; standard provisions

A. No annuity or pure endowment contract except a reversionary annuity otherwise called a survivorship annuity and except a group annuity contract shall be delivered or issued for delivery in this state unless it contains in substance the following provision or provisions which in the opinion of the commissioner of insurance are more favorable to the holders of such contracts:

(1) A provision that there shall be a period of grace, either of thirty days or of one month, within which any stipulated payment to the insurer falling due after the first may be made, during which period of grace the contract shall continue in full force; but if a claim arises under the contract on account of death during the said period of grace before the overdue payment to the insurer or the deferred payments of the current contract year, if any, are made, the amount of such payments, with interest, not in excess of six per cent per annum, on any overdue payments, may be deducted from any amount payable under the contract in settlement.

(2) If any statements, other than those relating to age, sex, and identity, are required as a condition of issuing the contract, a provision that the contract shall be incontestable after it has been in force during the lifetime of the person or each of the persons as to whom such statements are required, for a period of two years from its date of issue, except where stipulated payments to the insurer have not been made, and except for violation of the conditions, if any, of the contract relating to military or naval service; and at the option of the insurer issuing the same, such contract may also except provisions relative to benefits in the event of total and permanent disability and provisions which grant insurance specifically against death by accident or accidental means.

(3) A provision that the contract shall constitute the entire contract between the parties, or if a copy of the application is endorsed upon or attached to the contract when issued, a provision that the contract and the application therefor shall constitute the entire contract between the parties.

(4) A provision that if the age or sex of the person or persons upon whose life or lives the contract is made, or of any of them, has been misstated, the amount payable or benefit accruing under the contract, shall be such as the stipulated payments to the insurer would have purchased according to the correct age or sex; and that if the insurer shall make any overpayments on account of any such misstatement, the amount thereof, with interest at a rate to be specified in the contract but not exceeding six per centum per annum, shall be charged against the current or next succeeding payment or payments to be made by the insurer under the contract.

(5) A provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the contract.

(6) A provision specifying the options available in the event of default in a stipulated payment after three full years stipulated payments have been made, together with a table showing, in figures, the options so available during each of the first twenty years after the issuance of the contract or for the term of the stipulated payments, if that be less than twenty years.

(7) A provision that at any time within one year from the date of default in making stipulated payments to the insurer, during the life of the annuitant and unless the cash surrender value, if any, has been paid, the contract will be reinstated, on the application of the person entitled thereto pursuant to the provisions of the contract, upon payment to the insurer of all overdue stipulated payments and of all indebtedness to the insurer on the contract with interest on both at a rate to be specified in the contract but not to exceed six per cent per annum, compounded annually; and in cases where applicable the contract may also contain a provision requiring, as a condition of reinstatement, evidence of insurability, including good health, satisfactory to the insurer.

(8)(a) A provision, prominently printed on the contract or attached thereto, notifying the insured that ten days are allowed, from the date of actual receipt of the contract, to examine its provisions. If the contract is not as explained by the company, its representative, or as understood by the insured, the contract may be surrendered within said ten-day period, and any premium advanced by the insured, upon the surrender, shall be immediately returned to him. The insurer shall have the option of printing, attaching, or endorsing the notice above required or a notice of equal prominence which, in the opinion of the commissioner of insurance, is not less favorable to the contract holder.

(b) If the policy is delivered by an agent or broker, a receipt shall be signed by the policyholder acknowledging delivery of the policy. The receipt shall contain the policy number and the date the delivery was completed. The delivery receipts required by this Subparagraph shall be retained by the insurer, its agent, or the broker for two consecutive years. The requirement of this Subparagraph shall not apply to any insurer that markets policies under a home service marketing distribution method and that issues a majority of its policies on a weekly or monthly basis.

(c) If the policy is delivered by mail, it shall be sent by certified mail, return receipt requested, or a certificate of mailing shall be obtained showing the date the policy was mailed to the policyowner. For policy issuances verified by a certificate of mailing, it is presumed that the policy is received by the policyowner ten days from the date of mailing. The receipts and the certificate of mailing described in this Section shall be retained by the insurer or agent for three years.

B. No contract for a reversionary annuity, otherwise called a survivorship annuity, shall be delivered or issued for delivery in this state unless it contains in substance the following provision or provisions which in the opinion of the commissioner of insurance are more favorable to the holders of such contracts:

(1) The provisions required by paragraphs (1), (2), (3), (4) and (5) of Sub-section A, except that under paragraph (1) the insurer may at its option provide for an equitable reduction of the amount of the annuity payments in settlement of any overdue or deferred payments, in lieu of a provision for a deduction of such payments from any amount payable upon a settlement under the contract.

(2) A provision that the contract may be reinstated at any time within three years from the date of default in making stipulated payments to the insurer, upon production of evidence of insurability, including good health, satisfactory to the insurer, and upon the making of all overdue payments and all payments due to the insurer on any loan made by it under the contract, with interest on both at a rate to be specified in the contract but not exceeding six per cent per annum, compounded annually.

C. Any of the foregoing provisions or portions thereof not applicable to non-participating contracts or not applicable to contracts for which a single stipulated payment to the insurer is made shall, to that extent, not be incorporated in such contract. The provisions of this Section shall not apply to contracts for deferred annuities or reversionary annuities upon the lives of beneficiaries under life insurance policies nor to group annuity contracts.

D. The provisions of this Section shall not apply to charitable gift annuities entered into on behalf of an organization qualified with the United States Internal Revenue Service for an exemption from federal income tax under Section 501(c)(3) of the Internal Revenue Code.

Acts 1958, No. 125; Acts 1990, No. 580, §1; Acts 1990, No. 715, §1, eff. July 20, 1990; Acts 1993, No. 141, §1.

§173.1. Standard nonforfeiture law for individual deferred annuities

A.(1) This Section shall be known as the "Standard Nonforfeiture Law for Individual Deferred Annuities".

(2) This Section shall not apply to any charitable gift annuity entered into on behalf of an organization qualified with the United States Internal Revenue Service for an exemption from federal income tax under Section 501(c)(3) of the Internal Revenue Code, reinsurance, group annuity purchases under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this state through an agent or other representative of the company issuing the contract.

(3) For purposes of this Section and R.S. 22:173(D), "charitable gift annuity" means a giving plan or method whereby a gift of a principal sum or a piece of property or a block of securities is made to an organization qualified with the United States Internal Revenue Service for an exemption from federal income tax under Section 501(c)(3) of the Internal Revenue Code. In exchange, such organization agrees to give the donor a fixed annual sum for life.

B. In the case of contracts issued on or after the operative date of this Section as defined in Subsection K, no contract of annuity, except as stated in Subsection A, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the contract-holder, upon cessation of payment of considerations under the contract.

(1) That upon cessation of payment of considerations under the contract, the company will grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in Subsections D, E, F, G, and H.

(2)(a) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company will pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in Subsections D, E, G, and H.

(b) Notwithstanding any other provision of law to the contrary, the company shall pay any cash surrender benefit not later than six months after demand therefor with surrender of the contract. Notwithstanding the above provision, if payment is not made within thirty days after demand therefor with surrender of the contract, the insurer shall pay, in addition to the cash surrender benefit, interest on the cash surrender benefit at the judicial interest rate set by Louisiana Civil Code Art. 2924 commencing from the date of surrender until the cash surrender benefit is paid in full within the six-month period.

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of such benefits.

(4) A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract, or any prior withdrawals from or partial surrenders of the contract.

Notwithstanding the requirements of this Subsection, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to such period would be less than twenty dollars monthly, the company may at its option terminate such contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by such payment shall be relieved of any further obligation under such contract.

C. Prior to July 1, 2005, any company may elect to comply with either the provisions of this Subsection or the provisions of Subsection L of this Section. On and after July 1, 2005, all companies shall comply with the provisions of Subsection L of this Section. The minimum values as specified in Subsections D, E, F, G, and H of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this Section:

(1)(a) Except as provided in Subparagraph (c) of this Paragraph, with respect to contracts providing for flexible considerations, the minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at a rate of interest of three percent per annum of percentages of the net considerations, as hereinafter defined, paid prior to such time, decreased by the sum of:

(i) Any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of three percent per annum, and

(ii) The amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amount credited by the company to the contract.

(b) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount not less than zero and shall be equal to the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of thirty dollars and less a collection charge of one dollar and twenty-five cents per consideration credited to the contract during that contract year. The percentages of net considerations shall be sixty-five percent of the net consideration for the first contract year and eighty-seven and one-half percent of the net considerations for the second and later contract years. Notwithstanding the provisions of the preceding sentence, the percentage shall be sixty-five percent of the portion of the total net consideration for any renewal contract year which exceeds by not more than two times the sum of those portions of the net considerations in all prior contract years for which the percentage was sixty-five percent.

(c) Notwithstanding the provisions of Subparagraph (a) of this Paragraph, beginning on July 1, 2002, and until July 1, 2005, the rate of interest provided for in the introductory paragraph and Item (i) of Subparagraph (a) shall be one and one-half percent; thereafter, the rate of interest shall be three percent.

(2) With respect to the contracts providing for fixed scheduled considerations, minimum nonforfeiture amounts shall be calculated on the assumption that considerations are paid annually in advance and shall be defined as for contracts with flexible considerations which are paid annually with two exceptions:

(a) The portion of the net consideration for the first contract year to be accumulated shall be the sum of sixty-five percent of the net consideration for the first contract year plus twenty-two and one-half percent of the excess of the net consideration for the first contract year over the lesser of the net considerations for the second and third contract years.

(b) The annual contract charge shall be the lesser of (i) thirty dollars or (ii) ten percent of the gross annual consideration.

(3) With respect to contracts providing for a single consideration, minimum nonforfeiture amounts shall be defined as for contracts with flexible considerations except that the percentage of net consideration used to determine the minimum nonforfeiture amount shall be equal to ninety percent and the net consideration shall be the gross consideration less a contract charge of seventy-five dollars.

D. Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

E. For contracts which provide cash surrender benefits, such cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent higher than the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

F. For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, and increased by any existing additional amounts credited by the company to the contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, such present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

G. For the purpose of determining the benefits calculated under Subsections E and F of this Section, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

H. Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

I. Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

J. For any contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of Subsections D, E, F, G, and H, additional benefits payable (i) in the event of total and permanent disability, (ii) as reversionary annuity or deferred reversionary annuity benefits, or (iii) as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this Section. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

K. After September 7, 1979, any company may file with the commissioner a written notice of its election to comply with the provisions of this Section after a specified date before September 7, 1980. After the filing of such notice, then upon such specified date, which shall be the operative date of this Section for such company, this Section shall become operative with respect to annuity contracts thereafter issued by such company. If a company makes no such election, the operative date of this Section for such company shall be September 7, 1980.

L. The minimum values as specified in Subsections D, E, F, G, and I of this Section of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this Subsection, as follows:

(1)(a) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at rates of interest as indicated in Paragraph (2) of this Subsection of the net considerations, as hereinafter defined, paid prior to such time, decreased by the sum of Items (i) and (ii) of this Subparagraph:

(i) Any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in Paragraph (2) of this Subsection; and

(ii) An annual contract charge of fifty dollars, accumulated at rates of interest as indicated in Paragraph (2) of this Subsection;

(iii) Any premium tax paid by the company for the contract, accumulated at rates of interest as indicated in Paragraph (2) of this Subsection; and

(iv) The amount of any indebtedness to the company on the contract, including interest due and accrued.

(b) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half percent of the gross considerations credited to the contract during that contract year.

(2) The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of three percent per annum and the following, which shall be specified in the contract if the interest rate will be reset:

(a) The five-year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date, or average over a period, rounded to the nearest one-twentieth of one percent, specified in the contract no longer than fifteen months prior to the contract issue date or redetermination date under Subparagraph (2)(d) of this Subsection;

(b) Reduced by one hundred twenty-five basis points;

(c) Where the resulting interest rate is not less than one percent; and

(d) The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis, and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.

(3) During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in Subparagraph (2)(b) of this Subsection by up to an additional one hundred basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Lacking such a demonstration that is acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.

(4) The commissioner may adopt rules to implement the provisions of Paragraph (3) of this Subsection and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts that the commissioner determines adjustments are justified.

Added by Acts 1979, No. 370, §4. Acts 1990, No. 715, §1, eff. July 20, 1990; Acts 1991, No. 951, §1; Acts 2002, 1st Ex. Sess., No. 129, §1, eff. June 16, 2002; Acts 2003, No. 386, §1; Acts 2004, No. 497, §1, eff. June 25, 2004.

§174. Group annuity contracts; definition; standard provisions

Any policy or contract, except a joint, reversionary or survivorship annuity contract, whereby annuities are payable dependent upon the continuation of the lives of more than one person, shall be deemed a group annuity contract. The person, firm or corporation to whom such contract is issued shall be deemed the "holder" of such contract. The term "annuitant," as used herein, refers to any person upon whose continued life such annuity is dependent.

No group annuity contract shall be delivered or issued for delivery in this state and no certificate shall be used in connection therewith unless it contains in substance the following provisions to the extent that such provisions are applicable to such contract or to such certificate, as the case may be, or provisions which in the opinion of the commissioner of insurance are more favorable to annuitants, or not less favorable to annuitants and more favorable to the holders:

(1) A provision in such contract that there shall be a period of grace, either of thirty days or of one month, within which any stipulated payment to be remitted by the holder to the insurer, falling due after one year from date of issue, may be made, subject, at the option of the insurer, to an interest charge thereon at a rate, to be specified in the contract, which shall not exceed six per cent per annum for the number of days of grace elapsing before such payment. (2) A provision in such contract specifying the document or documents which shall constitute the entire contract between the parties; the document or documents so specified shall be only (a) the contract, (b) the contract together with the application of the holder of which a copy is attached thereto, or (c) the contract together with the application of the holder of which a copy is attached thereto and the individual applications of annuitants on file with the insurer and referred to therein.

(3) A provision in such contract, with an appropriate reference thereto in the certificate, for the equitable adjustment of the benefits payable under the contract or of the stipulated payments thereunder, if it be found that the sex, age, service, salary or any other fact determining the amount of any stipulated payment or the amount or date or dates of payment of any benefit with respect to any annuitant covered thereby, has been misstated.

(4) A provision or provisions in such contract, with an appropriate reference thereto in the certificate, specifying the nature and basis of ascertainment of the benefits which will be available to an annuitant who contributes to the cost of the annuity and the conditions of payment thereof in the event of either the termination of employment of the annuitant, except by death, or the discontinuance of stipulated payments under the contract. Such provision or provisions shall, in either of such events, make available to an annuitant who contributes to the cost of the annuity a paid-up annuity payable commencing at a fixed date in an amount at least equal to that purchased by the contributions of the annuitant, determinable as of the respective dates of payment of the several contributions, as shown by a schedule included in the contract for that purpose, based upon the same mortality table, rate of interest and loading formula used in computing the stipulated payments under such contract. Such provision or provisions may, by way of exception to the foregoing, provide that if the amount of the annuity determined as aforesaid from such fixed commencement date would be less than sixty dollars annually, the insurer may at its option, in lieu of granting such paid-up annuity, pay a cash surrender value at least equal to that hereinafter provided. If a cash surrender value, in lieu of such paid-up annuity, is allowed to the annuitant by the terms of such contract, it may be either in a single sum or in equal installments over a period of not more than twelve months and it shall be at least equal to either (a) or (b), whichever is less: (a) the amount of reserve attributable to the annuitant's contributions less a surrender charge not exceeding thirty-five per centum of the average annual contribution made by the annuitant; or (b) the amount which would be payable as a death benefit at the date of surrender. Such contract shall also provide that in case of the death of the annuitant, before the commencement date of the annuity, the insurer shall pay a death benefit at least equal to the aggregate amount of the annuitant's contributions, without interest. If any benefits are available to the holder in either of such events the contract shall contain a provision or provisions specifying the nature and basis of ascertainment of such benefits.

(5) A provision in such contract that the insurer will issue to the holder of the contract for delivery to each annuitant who contributes thereunder an individual certificate setting forth a statement in substance of the benefits to which he is entitled under such contract.

Acts 1958, No. 125.

§175. Group life insurance defined; eligibility; payment of premiums; limits and coverage

A. A policy of group life insurance may be issued to any of the following groups or combination thereof, or to the trustees thereof who shall be deemed the policyholder:

(1) Employees or retired employees of any employer or subsidiary employer, individual proprietors or partners if the employee is an individual proprietor or partnership. Directors shall not be considered as employees unless they perform substantial duties for the employer in addition to those usually performed as directors.

(2) Full privileged and contributing members or employees of members of any organization or association which has been formed for purposes other than procuring insurance for the members or employees.

(3) Life insurance covering only the lives of all members of a group of persons, numbering not less than ten new entrants to the group yearly, who become borrowers from one financial institution, including subsidiary or affiliated companies, or who become purchasers of securities, merchandise, or other property from one vendor under agreement to repay the sum borrowed or to pay the balance of the price of the securities, merchandise, or other property purchased, whether in installments or in a single sum on a stated date, to the extent of their indebtedness to said financial institution or vendor, written under a policy which may be issued upon the application of and made payable to the financial institution or vendor or other creditor to whom such vendor may have transferred title to the indebtedness, as beneficiary, the premium on such policy to be payable by the financial institution, vendor, or other creditor, either from funds of the financial institution, vendor, or other creditor, or from charges collected from the insured debtors or from both.

(4) Life insurance covering the members of one or more companies, batteries, troops, or other units of the national guard of any state, written under a policy issued to the commanding general of the national guard who shall be deemed to be the employer for the purposes of this section, the premium on which is to be paid by the members of such units for the benefit of persons other than the employer.

B. Each policy of group life insurance may cover one or more employees or members at date of issue.

(1) The amounts of insurance under the policy must be based upon some plan precluding individual selection, either by the insurer, member, employer, or trustee.

(2) The premium for the policy shall be paid by the policyholder either wholly from the policyholder's funds or funds contributed by him, partially from such funds and partially from funds contributed by the insureds or from funds contributed entirely by the insureds.

(3) A policy on which all or a part of the premium is to be derived from funds contributed by the insured employees may be placed in force, excluding any employee as to whom evidence of individual insurability is not satisfactory to the insurer. A policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, or all except as to whom evidence of individual insurability is not satisfactory to the insurer. An insurer may but shall not be required to establish a percentage of eligible employees who are required to enroll and participate in a group policy if the entire premium is not paid by the employer.

(4) The persons eligible for group insurance, except for that insurance issued pursuant to Paragraph A(3) of this Section shall be all the employees of an employer or all the members of any association or employees of such members, or all of any class or classes thereof determined by conditions pertaining to their employment or membership.

(5) The policy shall be issued to insure lives for the benefits of persons other than the employer or association, except those policies issued pursuant to Paragraph A(3) of this Section in which case benefits shall be paid to the creditor as his interest may appear.

(6) Any policy issued under this section may provide for the readjustment of the rate of premium based on the experience thereunder at the end of the first year or of any subsequent year of insurance thereunder and such readjustment may be made retroactive only for such policy year. Any refund on any plan for readjustment of the rate of premium based on the experience of the group policies hereafter issued, and any dividend paid under such policies may be used to reduce the employer's share of the cost of coverage, except that if the aggregate refunds or dividends under such group policy and in any other group policy or contract issued to the policyholder exceed the aggregate contributions of the employer toward the cost of the coverages, such excess shall be applied by the policyholder for the sole benefit of insured employees.

(7) Insurance under any group life insurance policy except those policies issued pursuant to Paragraph (A)(3) of this Section, may, if seventy-five percent of the then insured employees or members who have eligible dependents elect, be extended to insure the spouse and minor children of the insured in amounts in accordance with the plan which precludes individual selection by the employees or members or by the employer or trustee.

Acts 1958, No. 125. Amended by Acts 1958, No. 99, §1; Acts 1962, No. 38, §1; Acts 1962, No. 158, §1; Acts 1962, No. 307, §1; Acts 1966, No. 170, §1; Acts 1968, No. 656, §1; Acts 1970, No. 399, §1; Acts 1972, No. 151, §1; Acts 1975, No. 555, §1; Acts 1977, No. 309, §1; Acts 1980, No. 656, §1; Acts 1995, No. 1184, §3; Acts 1999, No. 474, §1; Acts 2001, No. 180, §1, eff. Jan. 1, 2002.

§176. Standard provisions for group life policies

Each policy of group life insurance as defined in R.S. 22:175 shall contain in substance the following provisions or, at the option of the insurer, provisions which in the opinion of the commissioner of insurance are not less favorable to the policyholder. However, Paragraphs (6) through (12) of this Section shall not apply to policies described in Paragraph (3) of Subsection A of R.S. 22:175, except that, where policies are issued pursuant to said Paragraph, the insurer shall issue to the policyholder for delivery to the person whose life is insured an individual certificate setting forth the insurance protection afforded, to whom it is payable, information relating to notice and proof of loss, and that the standard provisions required for individual life insurance policies shall not apply to group life insurance policies.

(1) The contract: A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or to his beneficiary.

(2) Incontestability: A provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue and that no statement made by an individual insured under the policy relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such individual's lifetime nor unless it is contained in a written instrument signed by him.

(3) Grace period: A provision that the policyholder is entitled to a grace period either of thirty days or one month within which the payment of any premium after the first may be made during which period of grace the death benefit coverage shall continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period.

(4) Misstatement of age: A provision specifying an equitable adjustment of premiums or of benefits or of both to be made in the event the age of a person insured has been misstated, such provision to contain a clear statement of the method of adjustment to be used.

(5) Insurability: A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his coverage.

(6) Beneficiary: A provision that any sum becoming due by reason of the death of the individual insured shall be payable to the beneficiary designated by such individual, subject to the provisions of the policy in the event there is no designated beneficiary, as to all or any part of such sum, living at the death of the individual insured and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding two hundred and fifty dollars to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the individual insured.

(7) Certificates: A provision that the insurer will issue to the policyholder for delivery to the employee, or member, whose life is insured under such policy, an individual certificate setting forth a statement as to the insurance protection to which he is entitled, to whom payable, together with the provisions concerning conversion rights.

(8) New persons eligible: A provision that from time to time all new employees or members eligible for insurance and desiring the same shall be added to the group or class thereof originally insured.

(9) Continuation to end of premium period: A provision, except in the case of a policy described in Paragraph (4) of Subsection B of Section 175 of this Title, that the termination of the employment of any employee or the membership of a member shall not terminate the insurance of such employee or member under the group policy until the expiration of such period for which the premium for such employee or member has been paid, not exceeding thirty-one days.

(10) Conversion on termination of eligibility: A provision that if the insurance, or any portion of it, on an individual covered under the policy ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, such individual shall be entitled to have issued to him by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits, provided application for the individual policy shall be made and the first premium paid to the insurer within thirty-one days after such termination. It is further provided that:

(a) The individual policy shall, at the option of such individual, be on any one of the forms, except term insurance, then customarily issued by the insurer at the age and for the amount applied for.

(b) The individual policy shall be in an amount not in any event in excess of the amount of life insurance which ceases because of such termination nor less than one thousand dollars unless a smaller amount of coverage was provided for such individual under the group policy, provided that any amount of insurance which matures on the date of such termination or has matured prior thereto under the group policy as an endowment payable to the individual insured, whether in one sum or installments or in the form of an annuity, shall not, for the purposes of this provision, be included in the amount which is considered to cease because of such termination.

(c) The premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such individual then belongs, and to his age attained on the effective date of the individual policy.

(11) Conversion on termination of policy: A provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured individuals, every individual insured thereunder at the date of such termination whose insurance terminates and who has been so insured for at least five years prior to such termination date shall be entitled to have issued to him by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by Paragraph (10) of this Section, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of (a) the amount of the individual's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of life insurance for which he is or becomes eligible under any group policy issued or reinstated by the same or another insurer within thirty-one days of such termination and (b) two thousand dollars.

(12) Death pending conversion: A provision that if a person insured under the group policy dies during the period within which he would have been entitled to have an individual policy issued to him in accordance with Paragraphs (10) and (11) of this Section and before such an individual policy shall have become effective, the amount of life insurance which he would have been entitled to have issued to him under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made.

(13) A provision that if the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which in the opinion of the commissioner is or are equitable to the insured persons and to the policyholder, but nothing herein shall be construed to require that group life insurance policies contain the same form of nonforfeiture provisions as are required for individual life insurance policies.

(14) Lump sum payment: Every group life insurance policy delivered or issued for delivery in this state shall allow selection by the beneficiary of an option to receive benefits in the form of a lump sum payment.

Acts 1958, No. 125. Amended by Acts 1966, No. 171, §1; Acts 1972, No. 161, §1; Acts 1981, No. 547, §1; Acts 2003, No. 125, §1.

§176.1. Group life insurance; exclusions; restrictions; contestability

A. No policy of group life insurance delivered or issued for delivery in this state shall contain any provision which excludes or restricts liability for death caused in a certain specified manner or occurring while the insured has a specified status, except the following provisions, excluding or restricting coverage in the event of death occurring:

(1) As a result of war declared or undeclared under conditions specified in the policy.

(2) While in the military, naval, or air forces of any country at war, declared or undeclared; or in any ambulance, medical, hospital, or civilian noncombatant unit serving with such forces, either while serving with or within six months after termination of service in such forces or units.

(3) As a result of self-destruction while sane or insane within two years from the date of issue of the policy.

(4) As a result of aviation under conditions specified in the policy.

(5) Within two years from the date of issue of the policy as a result of a specified hazardous occupation or occupations or while the insured is residing in a specified foreign country or countries.

B. The commissioner may also allow provisions which, in the opinion of the commissioner, are substantially the same or more favorable to policyholders as those provisions provided for in Paragraphs (A)(1) through (5).

C. In the event of death as to which there is an exclusion or restriction not prohibited by Paragraph (A)(1), (3), (4), or (5) or is allowed by the commissioner, the insurer shall pay an amount not less than the reserve on the face amount of the policy, together with the reserve for any paid-up additions thereto, and any dividends standing to the credit of the policy, less any indebtedness to the insurer on the policy, including interest due or accrued.

D. In the event of death as to which there is an exclusion or restriction not prohibited by Paragraph (A)(2) or is allowed by the commissioner, the insurer shall pay the greater of:

(1) An amount not less than the reserve on the face amount of the policy, together with the reserve for any paid-up additions thereto, and any dividends standing to the credit of the policy, less any indebtedness to the insurer on the policy, including interest due or accrued; or

(2) The amount of the gross premiums charged on the policy less dividends paid in cash or used in the payment of premiums thereon and less any indebtedness to the insurer on the policy, including interest due or accrued.

E. A clause in any policy of group life insurance, issued under this Code, providing that such policy shall be incontestable after a specified period shall preclude only a contest of the validity of the policy and shall not preclude the assertion at any time of defenses based upon provisions which exclude or restrict coverage as provided in this Section, whether or not such restrictions or exclusions are excepted in such clause, nor upon a provision regarding misstatement of age as provided in R.S. 22:176(4), whether or not such provision is excepted in such clause.

F. Nothing contained herein shall apply to any provision in a group life insurance policy for additional benefits in the event of death by accident or accidental means.

Acts 2003, No. 128, §1.

§177. Written notice required before lapsing life policies

No life insurer shall within one year after default in payment of any premium, installment, loan or interest, declare forfeited or lapsed any policy issued or renewed, and not issued upon the payment of monthly or weekly premiums or for a term of one year or less, for non-payment when due of any premium, installment, loan or interest, or any portion thereof required by the terms of the policy to be paid, unless a written or printed notice stating:

(1) The amount of such premium, installment, loan or interest, or portion thereof due on such policy; and

(2) The place where it shall be paid and the person to whom the same is payable, shall have been duly addressed and mailed to the person whose life is insured or the assignee of the policy if notice of the assignment has been given to the insurer, at the last known post office address of such insured or assignee, postage prepaid by the insurer or any person appointed by it to collect such payment, at least fifteen and not more than forty-five days prior to the date when the same is payable.

No policy shall in any case be forfeited or declared forfeited or lapsed until the expiration of thirty days after the mailing of such notice. Any payment demanded by such notice and made within the time limit shall be taken to be full compliance with the requirements of the policy in respect to the time of such payment.

The affidavit of any officer, clerk or agent of the insurer or of anyone authorized to mail such notice that the notice required by this section has been duly addressed and mailed by the insurer issuing such policy, shall be presumptive evidence that such notice has been duly given. No action shall be maintained to recover under a forfeited policy, unless the same is instituted within two years from the day upon which default was made in paying the premium, installment, interest or portion thereof for which it is claimed that forfeiture ensued. This Section shall not apply to group insurance policies.

Acts 1958, No. 125.

§178. Mortality endowments prohibited

A. No life insurer (including industrial, service, non-profit funeral associations and fraternal benefit societies) shall be permitted to issue policies, certificates or contracts to policyholders or members stipulating for the establishment of its policyholders or members into divisions and classes for the purpose of providing for the payment of benefits from special funds created for such purpose to the oldest member of the division and class or to the member of the division and class whose policy has been in force the longest period of time upon the death of the member in such division and class, except as provided in Sub-section B.

B. Any life insurer specified in Sub-section A heretofore operating on the plan specified in Sub-section A in this state since before October 1, 1948 may continue so to do upon condition that such life insurer shall not after that date establish its policyholders or members into divisions or classes other than the divisions or classes actually containing subsisting policies or certificates as of July 28th, 1936.

Acts 1958, No. 125.

§179. Benefits required by domiciliary state--Louisiana residents entitled to

Every policy of life insurance and every benefit contract issued by any alien or foreign insurer to an insured or beneficiary who is a citizen or resident of this state at the time the policy was issued, shall as to all rights, privileges or duties of the insurer, the insured or the beneficiary therein, be so interpreted, performed and enforced as to give accord and extend to such insured or beneficiary named therein and all parties legally represented or claiming through such original parties, the benefit of all legislative or legal enactments of any sort within the state, territory or country where the insurer issuing such policy or contract is domiciled.

Acts 1958, No. 125.

§180. Agent of life insurer not to be made agent of insured

No life insurer shall provide in any application, policy or certificate of insurance that the person soliciting such insurance or any person who is engaged in the business of soliciting insurance for the insurer and whose compensation is either paid by the insurer or is contingent upon the issuance of such policy, is the agent of the person insured. No such insurer shall insert in any policy or contract any provision to make the acts or representations of such person binding upon the insured.

Acts 1958, No. 125.

§181. Inapplicability to reinsurance

R.S. 22:170, 22:173, and 22:176 shall not apply to contracts of reinsurance.

Acts 1958, No. 125.

§182. Interest on life insurance benefits

Interest on benefits of a life insurance policy shall begin to accrue twenty days from the date of receipt of due proof of death by the insurer. The rate of interest shall be calculated at the same rate paid on deposits with the insurer. This Section shall not apply to any accidental death or dismemberment policy claim or to any insurer that markets under the Home Service Marketing distribution method and issues a majority of its policies on a weekly or monthly basis. This Section shall not deprive the beneficiary of any greater benefits due under the life insurance policy.

Acts 1995, No. 1103, §1.

PART V-A. VIATICAL SETTLEMENTS

§191. Definitions

As used in this Part:

(1) "Advertising" means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the internet, or similar communications media, including film strips, motion pictures, and videos published, disseminated, circulated, or placed before the public, directly or indirectly, for the purpose of creating an interest in or inducing a person to purchase or sell a life insurance policy or an interest in a life insurance policy pursuant to a viatical settlement contract or a viatical settlement purchase agreement.

(2) "Business of viatical settlements" means an activity involved in but not limited to the offering, solicitation, negotiation, procurement, effectuation, purchasing, investing, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, hypothecating, or in any other manner of viatical settlement contracts or purchase agreements.

(3) "Chronically ill" means:

(a) Being unable to perform at least two activities of daily living (i.e., eating, toileting, transferring, bathing, dressing, or continence);

(b) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

(c) Having a level of disability similar to that described in Subparagraph (a) of this Paragraph as determined by the secretary of health and human services.

(4)(a) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any entity that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract, but:

(i) Whose principal activity related to the transaction is providing funds to effect the viatical settlement or purchase of one or more viaticated policies; and

(ii) Who has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts.

(b) Financing entity does not include a nonaccredited investor or viatical settlement purchaser.

(5) "Fraudulent viatical settlement act" includes:

(a) Acts or omissions committed by any person who, knowingly or with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits or permits its employees or its agents to engage in acts including:

(i) Presenting, causing to be presented, or preparing with knowledge or belief that it will be presented to or by a viatical settlement provider, viatical settlement broker, viatical settlement purchaser, viatical settlement investment agent, financing entity, insurer, insurance producer, or any other person false material information or concealing material information as part of, in support of, or concerning a fact material to one or more of the following:

(aa) An application for the issuance of a viatical settlement contract or insurance policy;

(bb) The underwriting of a viatical settlement contract or insurance policy;

(cc) A claim for payment or benefit pursuant to a viatical settlement contract or insurance policy;

(dd) Premiums paid on an insurance policy, or as a result of a viatical settlement purchase agreement;

(ee) Payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract, viatical settlement purchase agreement, or insurance policy;

(ff) The reinstatement or conversion of an insurance policy;

(gg) In the solicitation, offer, effectuation, or sale of a viatical settlement contract, insurance policy, or viatical settlement purchase agreement;

(hh) The issuance of written evidence of a viatical settlement contract, viatical settlement purchase agreement, or insurance; or

(ii) A financing transaction.

(ii) Employing any device, scheme, or artifice to defraud relative to viaticated policies.

(b) In the furtherance of a fraud or to prevent the detection of a fraud any person commits or permits its employees or its agents to:

(i) Remove, conceal, alter, destroy, or sequester from the commissioner the assets or records of a licensee or other person engaged in the business of viatical settlements;

(ii) Misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person;

(iii) Transact the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of viatical settlements; or

(iv) File with the commissioner or the chief insurance regulatory official of another jurisdiction a document containing false information or otherwise conceals information about a material fact from the commissioner.

(c) Embezzlement, theft, misappropriation, or conversion of monies, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policy owner, or any other person engaged in the business of viatical settlements or insurance;

(d) Recklessly entering into, brokering, or otherwise dealing in a viatical settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the viator or the viator's agent intended to defraud the policy's issuer. "Recklessly" means engaging in the conduct in conscious and clearly unjustifiable disregard of a substantial likelihood of the existence of the relevant facts or risks, such disregard involving a gross deviation from acceptable standards of conduct; or

(e) Attempting to commit, assisting, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this Paragraph.

(6) "Person" means a natural person or a legal entity, including but not limited to an individual, partnership, limited liability company, association, trust, or corporation.

(7) "Policy" means an individual or group policy, group certificate, contract, or arrangement of life insurance affecting the rights of a resident of this state or bearing a reasonable relation to this state, regardless of whether delivered or issued for delivery in this state.

(8) "Related provider trust" means a titling trust or other trust established by a licensed viatical settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust shall have a written agreement with the licensed viatical settlement provider under which the licensed viatical settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to viatical settlement transactions available to the commissioner as if those records and files were maintained directly by the licensed viatical settlement provider.

(9) "Special purpose entity" means a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide either directly or indirectly access to institutional capital markets for a financing entity or licensed viatical settlement provider.

(10) "Terminally ill" means having an illness or sickness that can reasonably be expected to result in death in twenty-four months or less.

(11) "Viatical settlement broker" means a person that on behalf of a viator and for a fee, commission, or other valuable consideration offers or attempts to negotiate viatical settlement contracts between a viator and one or more viatical settlement providers. Notwithstanding the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator. The term does not include an attorney, certified public accountant, or a financial planner accredited by a nationally recognized accreditation agency who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider or purchaser.

(12) "Viatical settlement contract" means a written agreement establishing the terms under which compensation or anything of value will be paid, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of any portion of the insurance policy or certificate of insurance. A viatical settlement contract also includes a contract for a loan or other financing transaction with a viator secured primarily by an individual or group life insurance policy, other than a loan by a life insurance company pursuant to the terms of the life insurance contract, or a loan secured by the cash value of a policy. A viatical settlement contract includes an agreement with a viator to transfer ownership or change the beneficiary designation at a later date regardless of the date that compensation is paid to the viator.

(13) "Viatical settlement investment agent" means a person who is an appointed or contracted agent of a licensed viatical settlement provider who solicits or arranges the funding for the purchase of a viatical settlement by a viatical settlement purchaser and who is acting on behalf of a viatical settlement provider.

(a) A viatical settlement investment agent shall not have any contact directly or indirectly with the viator or have knowledge of the identity of the viator.

(b) A viatical settlement investment agent is deemed to represent the viatical settlement provider of whom the viatical settlement investment agent is an appointed or contracted agent.

(14) "Viatical settlement provider" means a person, other than a viator, that enters into or effectuates a viatical settlement contract. Viatical settlement provider does not include:

(a) A bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan;

(b) The issuer of a life insurance policy providing accelerated benefits under Regulation 44 and pursuant to the contract;

(c) An authorized or eligible insurer that provides stop loss coverage to a viatical settlement provider, purchaser, financing entity, special purpose entity, or related provider trust;

(d) A natural person who enters into or effectuates no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit;

(e) A financing entity;

(f) A special purpose entity;

(g) A related provider trust;

(h) A viatical settlement purchaser; or

(i) An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended, and who purchases a viaticated policy from a viatical settlement provider.

(15) "Viatical settlement purchase agreement" means a contract or agreement, entered into by a viatical settlement purchaser, to which the viator is not a party, to purchase a life insurance policy or an interest in a life insurance policy, that is entered into for the purpose of deriving an economic benefit.

(16) "Viatical settlement purchaser" means a person who gives a sum of money as consideration for a life insurance policy or an interest in the death benefits of a life insurance policy, or a person who owns or acquires or is entitled to a beneficial interest in a trust that owns a viatical settlement contract or is the beneficiary of a life insurance policy that has been or will be the subject of a viatical settlement contract, for the purpose of deriving an economic benefit. Viatical settlement purchaser does not include:

(a) A licensee under this Part;

(b) An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended;

(c) A financing entity;

(d) A special purpose entity; or

(e) A related provider trust.

(17) "Viaticated policy" means a life insurance policy or certificate that has been acquired by a viatical settlement provider pursuant to a viatical settlement contract.

(18) "Viator" means the owner of a life insurance policy or a certificate holder under a group policy who enters or seeks to enter into a viatical settlement contract. For the purposes of this Part, a viator shall not be limited to an owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a terminal or chronic illness or condition except where specifically addressed. Viator does not include:

(a) A licensee under this Part;

(b) An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended;

(c) A financing entity;

(d) A special purpose entity; or

(e) A related provider trust.

Acts 2003, No. 343, §1.

§191.1. License requirements

A.(1) A person shall not operate as a viatical settlement provider or viatical settlement broker without first obtaining a license from the commissioner of the state of residence of the viator. However, any person who holds a resident or nonresident insurance producer license for life or annuity pursuant to Part XXV of this Chapter may act as a viatical settlement broker and shall be subject to the provisions of this Part as if such person is a licensed viatical settlement broker. If there is more than one viator on a single policy and the viators are residents of different states, the viatical settlement shall be governed by the law of the state in which the viator having the largest percentage ownership resides or, if the viators hold equal ownership, the state of residence of one viator agreed upon in writing by all viators.

(2) A person shall not operate as a viatical settlement investment agent without first obtaining a license from the commissioner of the state of residence of the viatical settlement purchaser. If there is more than one purchaser of a single policy and the purchasers are residents of different states, the viatical settlement purchase agreement shall be governed by the law of the state in which the purchaser having the largest percentage ownership resides or, if the purchasers hold equal ownership, the state of residence of one purchaser agreed upon in writing by all purchasers.

B. Application for a viatical settlement provider, viatical settlement broker, or viatical settlement investment agent license shall be made to the commissioner by the applicant on a form prescribed by the commissioner, and these applications shall be accompanied by the fees specified in R.S. 22:1078.

C. Licenses may be renewed from year to year on the anniversary date upon payment of the annual renewal fees specified in R.S. 22:1078. Failure to pay the fees by the renewal date results in expiration of the license.

D. The applicant shall provide information on forms required by the commissioner. The commissioner shall have authority, at any time, to require the applicant to fully disclose the identity of all stockholders, partners, officers, members, and employees, and the commissioner may, in the exercise of the commissioner's discretion, refuse to issue a license in the name of a legal entity if not satisfied that any officer, employee, stockholder, partner, or member thereof who may materially influence the applicant's conduct meets the standards of this Part.

E. A license issued to a legal entity authorizes all partners, officers, members, and designated employees to act as viatical settlement providers, viatical settlement brokers, or viatical settlement investment agents, as applicable, under the license, and all those persons shall be named in the application and any supplements to the application.

F. Upon the filing of an application and the payment of the license fee, the commissioner shall make an investigation of each applicant and issue a license if the commissioner finds that the applicant:

(1) If a viatical settlement provider, has provided a detailed plan of operation;

(2) Is competent and trustworthy and intends to act in good faith in the capacity involved by the license applied for;

(3) Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied for;

(4) If a legal entity, provides a certificate of good standing from the state of its domicile; and

(5) If a viatical settlement provider or viatical settlement broker, has provided an antifraud plan that meets the requirements of R.S. 22:197(G).

G. The commissioner shall not issue a license to a nonresident applicant, unless a written designation of an agent for service of process is filed and maintained with the commissioner or the applicant has filed with the commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the commissioner.

H. A viatical settlement provider, viatical settlement broker, or viatical settlement investment agent shall notify the commissioner of any changes to the information submitted in association with the application, including but not limited to new or revised information about officers, ten percent or more stockholders, partners, directors, members, or designated employees, a change in the name or corporate structure, or any other such modification within thirty days of the change.

Acts 2003, No. 343, §1.

§192. License revocation and denial

A. The commissioner may refuse to issue, suspend, revoke, or refuse to renew the license of a viatical settlement provider, viatical settlement broker, or viatical settlement investment agent if the commissioner finds that:

(1) There was any material misrepresentation in the application for the license;

(2) The licensee or any officer, partner, member, or key management personnel has been convicted of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown to be untrustworthy or incompetent;

(3) The viatical settlement provider demonstrates a pattern of unreasonable payments to viators;

(4) The licensee or any officer, partner, member, or key management personnel has been found guilty of, or has pleaded guilty or nolo contendere to, any felony or to a misdemeanor involving fraud or moral turpitude, regardless of whether a judgment of conviction has been entered by the court;

(5) The viatical settlement provider has entered into any viatical settlement contract that has not been approved pursuant to this Part;

(6) The viatical settlement provider has failed to honor contractual obligations set out in a viatical settlement contract or a viatical settlement purchase agreement;

(7) The licensee no longer meets the requirements for initial licensure;

(8) The viatical settlement provider has assigned, transferred, or pledged a viaticated policy to a person other than a viatical settlement provider licensed in this state, viatical settlement purchaser, an accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended, financing entity, special purpose entity, or related provider trust;

(9) The licensee or any officer, partner, member, or key management personnel has violated any provision of this Part; or

(10) The licensee has failed to file the annual report required by this Part.

B. If the commissioner denies a license application or suspends, revokes, or refuses to renew the license of a viatical settlement provider, viatical settlement broker, or viatical settlement investment agent, the commissioner shall conduct a hearing in accordance with Part XXIX of this Chapter, subject to the provisions of Chapter 13-B of Title 49 of the Louisiana Revised Statutes of 1950. Such hearing shall not be required in association with the expiration of a license due to failure to pay the annual renewal fee.

Acts 2003, No. 343, §1.

§192.1. Approval of viatical settlement contracts and disclosure statements

A person shall not use a viatical settlement contract or provide to a viator a disclosure statement form or use any advertising material in this state unless filed with and approved by the commissioner. The commissioner shall disapprove a viatical settlement contract form, disclosure statement form, or advertising if, in the commissioner's opinion, the contract or advertising material or provisions contained therein are unreasonable, contrary to the interests of the public, otherwise misleading or unfair to the viator, or otherwise in violation of this Part. Each submission for approval shall be accompanied by a fee as required in R.S. 22:1078.

Acts 2003, No. 343, §1.

§193. Reporting requirements and privacy

A. Each licensee shall file with the commissioner on or before March first of each year an annual statement containing such information as the commissioner may prescribe by regulation. Such information shall be limited to those transactions where the viator is a resident of this state. If there is more than one viator on a single policy and the viators are residents of different states, the viatical settlement shall be governed by the law of the state in which the viator having the largest percentage of ownership resides or, if the viators hold equal percentages of ownership, the state of residence of one viator agreed upon in writing by all viators.

B. Except as otherwise allowed or required by law, a viatical settlement provider, viatical settlement broker, viatical settlement investment agent, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity shall not disclose that identity as an insured, or the insured's financial or medical information to any other person unless the disclosure:

(1) Is necessary to effect a viatical settlement between the viator and a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

(2) Is necessary to effect a viatical settlement purchase agreement between the viatical settlement purchaser and a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

(3) Is provided in response to an investigation or examination by the commissioner or any other governmental officer or agency or pursuant to the requirements of R.S. 22:197(C);

(4) Is a term of or condition to the transfer of a policy by one viatical settlement provider to another viatical settlement provider;

(5) Is necessary to permit a financing entity, related provider trust, or special purpose entity to finance the purchase of policies by a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

(6) Is necessary to allow the viatical settlement provider or viatical settlement broker or their authorized representatives to make contacts for the purpose of determining health status; or

(7) Is required to purchase stop loss coverage.

Acts 2003, No. 343, §1.

§193.1. Examination and investigations

A. Authority, scope, and scheduling of examinations.

(1) The commissioner may conduct an examination under this Part of a licensee as often as the commissioner in his or her sole discretion deems appropriate.

(2) For purposes of completing an examination of a licensee under this Part, the commissioner may examine or investigate any person, or the business of any person, insofar as the examination or investigation is, in the sole discretion of the commissioner, necessary or material to the examination of the licensee.

(3) In lieu of an examination under this Part of any foreign or alien licensee licensed in this state, the commissioner may, at the commissioner's discretion, accept an examination report on the licensee as prepared by the commissioner for the licensee's state of domicile or port-of-entry state.

B. Record retention requirements.

(1) A person required to be licensed by this Part shall for five years retain copies of all:

(a) Proposed, offered, or executed contracts, purchase agreements, underwriting documents, policy forms, and applications from the date of the proposal, offer, or execution of the contract or purchase agreement, whichever is later;

(b) Checks, drafts, or other evidence and documentation related to the payment, transfer, deposit, or release of funds from the date of the transaction; and

(c) Other records and documents related to the requirements of this Part.

(2) This Section does not relieve a person of the obligation to produce these documents to the commissioner after the retention period has expired if the person has retained the documents.

(3) Records required to be retained by this Section must be legible and complete and may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media, or by any process that accurately reproduces or forms a durable medium for the reproduction of a record.

C. Conduct of examinations.

(1) Upon determining that an examination should be conducted, the commissioner shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the Examiners Handbook adopted by the National Association of Insurance Commissioners (NAIC). The commissioner may also employ such other guidelines or procedures as the commissioner may deem appropriate.

(2) Every licensee or person from whom information is sought, its officers, directors, and agents shall provide to the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets, and computer or other recordings relating to the property, assets, business, and affairs of the licensee being examined. The officers, directors, employees, and agents of the licensee or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of a licensee by its officers, directors, employees, or agents to submit to examination or to comply with any reasonable written request of the commissioner shall be grounds for suspension or refusal of, or nonrenewal of, any license or authority held by the licensee to engage in the viatical settlement business or other business subject to the commissioner's jurisdiction. Any proceedings for suspension, revocation, or refusal of any license or authority shall be conducted pursuant to Part XXIX of this Chapter, subject to the provisions of Chapter 13-B of Title 49 of the Louisiana Revised Statutes of 1950.

(3) The commissioner shall have the power to issue subpoenas, to administer oaths, and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court.

(4) When making an examination under this Part, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the reasonable cost of which shall be borne by the licensee that is the subject of the examination.

(5) Nothing contained in this Part shall be construed to limit the commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

(6) Nothing contained in this Part shall be construed to limit the commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or licensee work papers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the commissioner may, in his or her sole discretion, deem appropriate.

D. Examination reports.

(1) Examination reports shall be comprised of only facts appearing upon the books, records, or other documents of the licensee, its agents, or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

(2) No later than sixty days following completion of the examination, the examiner in charge shall file with the commissioner a verified written report of examination under oath. Upon receipt of the verified report, the commissioner shall transmit the report to the licensee examined, together with a notice that shall afford the licensee examined a reasonable opportunity of not more than thirty days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(3) In the event the commissioner determines that regulatory action is appropriate as a result of an examination, the commissioner may initiate any proceedings or actions provided by law.

E. Confidentiality of examination information.

(1) Names and individual identification data for all viators shall be considered private and confidential information and shall not be disclosed by the commissioner, unless required by law.

(2) Except as otherwise provided in this Part, all examination reports, working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the commissioner or any other person in the course of an examination made under this Part, or in the course of analysis or investigation by the commissioner of the financial condition or market conduct of a licensee shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be made public by the commissioner, the National Association of Insurance Commissioners (NAIC), or any other person, except to the insurance departments of other states or in any adjudicatory hearing or court proceeding invoked by the commissioner in accordance with the provisions of this Chapter.

(3) Neither the commissioner nor any person that received the documents, material, or other information while acting under the authority of the commissioner, including the NAIC and its affiliates and subsidiaries, shall be permitted to testify in any private civil action concerning any confidential documents, materials, or information subject to Paragraph (1) of this Subsection.

(4) In order to assist in the performance of the commissioner's duties, the commissioner:

(a) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to Paragraph (1) of this Subsection, with other state, federal, and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, communication, or other information;

(b) May receive documents, materials, communications, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(c) May enter into agreements governing sharing and use of information consistent with this Subsection.

(5) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this Section or as a result of sharing as authorized in Paragraph (4) of this Subsection.

(6) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this Subsection shall be available and enforced in any proceeding in, and in any court of, this state.

(7) Nothing contained in this Part shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto to the commissioner of any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, or to the NAIC, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this Part.

F. Conflict of interest.

(1) An examiner may not be appointed by the commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this Part. This Section shall not be construed to automatically preclude an examiner from being:

(a) A viator;

(b) An insured in a viaticated insurance policy; or

(c) A beneficiary in an insurance policy that is proposed to be viaticated.

(2) Notwithstanding the requirements of this clause, the commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under this Part.

G. Cost of examinations.

Whenever the commissioner of insurance examines a licensee under this Part, all expenses incurred by the commissioner of insurance in conducting such examination, including the expenses and fees of examiners, auditors, accountants, actuaries, attorneys, or clerical or other assistants who are employed by the commissioner to make the examinations, shall be paid by the licensee examined. All funds so generated and collected shall be used only to defray the expenses of reviews and examinations and for no other purpose.

H. Immunity from liability.

(1) No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives, or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this Part.

(2) No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under this Part, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This Paragraph does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in Paragraph (1).

(3) A person identified in Paragraph (1) or (2) of this Subsection shall be entitled to an award of attorney fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this Part and the party bringing the action was not substantially justified in doing so. For purposes of this Section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

I. Investigative authority of the commissioner. The commissioner may investigate suspected fraudulent viatical settlement acts and persons engaged in the business of viatical settlements.

Acts 2003, No. 343, §1.

§194. Disclosure

A. With each application for a viatical settlement, a viatical settlement provider or viatical settlement broker shall provide the viator with at least the following disclosures no later than the time the application for the viatical settlement contract is signed by all parties. The disclosures shall be provided in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker and shall provide the following information:

(1) There are possible alternatives to viatical settlement contracts including any accelerated death benefits or policy loans offered under the viator's life insurance policy.

(2) Some or all of the proceeds of the viatical settlement may be taxable under federal income tax and state franchise and income taxes, and assistance should be sought from a professional tax advisor.

(3) Proceeds of the viatical settlement could be subject to the claims of creditors.

(4) Receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlement, and advice should be obtained from the appropriate government agencies.

(5) The viator has the right to rescind a viatical settlement contract for fifteen calendar days after the receipt of the viatical settlement proceeds by the viator, as provided in this Part. If the insured dies during the rescission period, the settlement contract shall be deemed to have been rescinded, subject to repayment of all viatical settlement proceeds and any premiums, loans, and loan interest to the viatical settlement provider or purchaser.

(6) Funds will be sent to the viator within three business days after the viatical settlement provider has received the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

(7) Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator. Assistance should be sought from a financial advisor.

(8) Disclosure to a viator shall include distribution of a brochure describing the process of viatical settlements. The NAIC's form for the brochure shall be used unless one is developed by the commissioner.

(9) The disclosure document shall contain the following language: "All medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years."

(10) The insured may be contacted by either the viatical settlement provider or broker or its authorized representative for the purpose of determining the insured's health status. This contact is limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less.

B. A viatical settlement provider shall provide the viator with at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and the viatical settlement provider or viatical settlement broker, and provide the following information:

(1) State the affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy to be viaticated.

(2) The document shall include the name, address, and telephone number of the viatical settlement provider.

(3) If an insurance policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be viaticated, the viator shall be informed of the possible loss of coverage on the other lives under the policy and shall be advised to consult with his or her insurance producer or the insurer issuing the policy for advice on the proposed viatical settlement.

(4) State the dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate. If known, the viatical settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate, and the viatical settlement provider's interest in those benefits.

(5) State the name, business address, and telephone number of the independent third-party escrow agent and the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

C. If the provider transfers ownership or changes the beneficiary of the insurance policy, the provider shall communicate the change in ownership or beneficiary to the insured within twenty days after the change.

D. A viatical settlement provider or its viatical settlement investment agent shall provide the viatical settlement purchaser with at least the following disclosures prior to the date the viatical settlement purchase agreement is signed by all parties. The disclosures shall be conspicuously displayed in any viatical purchase contract or in a separate document signed by the viatical settlement purchaser and viatical settlement provider or viatical settlement investment agent, and shall make the following disclosure to the viatical settlement purchaser:

(1) The purchaser will receive no returns (i.e., dividends and interest) until the insured dies.

(2) The actual annual rate of return on a viatical settlement contract is dependent upon an accurate projection of the insured's life expectancy and the actual date of the insured's death. An annual "guaranteed" rate of return is not determinable.

(3) The viaticated life insurance contract should not be considered a liquid purchase since it is impossible to predict the exact timing of its maturity and the funds probably are not available until the death of the insured. There is no established secondary market for resale of these products by the purchaser.

(4) The purchaser may lose all benefits or may receive substantially reduced benefits if the insurer goes out of business during the term of the viatical investment.

(5) The purchaser is responsible for payment of the insurance premium or other costs related to the policy, if required by the terms of the viatical purchase agreement. These payments may reduce the purchaser's return. If a party other than the purchaser is responsible for the payment, the name and address of that party also shall be disclosed.

(6) The purchaser is responsible for payment of the insurance premiums or other costs related to the policy if the insured returns to health and to disclose the amount of such premiums, if applicable.

(7) State the name and address of any person providing escrow services and the relationship to the broker.

(8) The amount of any trust fees or other expenses to be charged to the viatical settlement purchaser shall be disclosed.

(9) State whether the purchaser is entitled to a refund of all or part of his or her investment under the settlement contract if the policy is later determined to be null and void.

(10) Disclose that group policies may contain limitations or caps in the conversion rights, additional premiums may have to be paid if the policy is converted, name the party responsible for the payment of the additional premiums, and, if a group policy is terminated and replaced by another group policy, state that there may be no right to convert the original coverage.

(11) Disclose the risks associated with policy contestability including but not limited to the risk that the purchaser will have no claim or only a partial claim to death benefits should the insurer rescind the policy within the contestability period.

(12) Disclose whether the purchaser will be the owner of the policy in addition to being the beneficiary, and if the purchaser is the beneficiary only and not also the owner, the special risks associated with that status, including but not limited to the risk that the beneficiary may be changed or the premium may not be paid.

(13) Describe the experience and qualifications of the person who determines the life expectancy of the insured, i.e., in-house staff, independent physicians, and specialty firms that weigh medical and actuarial data, the information this projection is based on, and the relationship of the projection maker to the viatical settlement provider, if any.

(14) Disclosure to an investor shall include distribution of a brochure describing the process of investment in viatical settlements. The NAIC's form for the brochure shall be used unless one is developed by the commissioner.

E. A viatical settlement provider or its viatical settlement investment agent shall provide the viatical settlement purchaser with at least the following disclosures no later than at the time of the assignment, transfer, or sale of all or a portion of an insurance policy. The disclosures shall be contained in a document signed by the viatical settlement purchaser and viatical settlement provider or viatical settlement investment agent, and shall make the following disclosures to the viatical settlement purchaser:

(1) Disclose all the life expectancy certifications obtained by the provider in the process of determining the price paid to the viator.

(2) State whether premium payments or other costs related to the policy have been escrowed. If escrowed, state the date upon which the escrowed funds will be depleted and whether the purchaser will be responsible for payment of premiums thereafter and, if so, the amount of the premiums.

(3) State whether premium payments or other costs related to the policy have been waived. If waived, disclose whether the investor will be responsible for payment of the premiums if the insurer that wrote the policy terminates the waiver after purchase and the amount of those premiums.

(4) Disclose the type of policy offered or sold, any additional benefits contained in the policy, and the current status of the policy.

(5) If the policy is term insurance, disclose the special risks associated with term insurance, including but not limited to the purchaser's responsibility for additional premiums if the viator continues the term policy at the end of the current term.

(6) State whether the policy is contestable.

(7) State whether the insurer that wrote the policy has any additional rights that could negatively affect or extinguish the purchaser's rights under the viatical settlement contract, what these rights are, and under what conditions these rights are activated.

(8) State the name and address of the person responsible for monitoring the insured's condition. Describe how often the monitoring of the insured's condition is done, how the date of death is determined, and how and when this information will be transmitted to the purchaser.

F. The viatical settlement purchase agreement is voidable by the purchaser at any time within three days after the disclosures mandated by Subsections D and E of this Section are received by the purchaser.

Acts 2003, No. 343, §1.

§194.1. General rules

A.(1) A viatical settlement provider entering into a viatical settlement contract shall first obtain:

(a) If the viator is the insured, a written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a viatical settlement contract;

(b) If applicable, a witnessed document in which the viator represents that the insured is terminally ill or chronically ill and that the illness was diagnosed after the policy was issued; and

(c) A document in which the insured consents to the release of his or her medical records to a viatical settlement provider and the viatical settlement broker.

(2) Within twenty days after a viator executes documents necessary to transfer any rights under an insurance policy or within twenty days of entering any agreement, option, promise, or any other form of understanding, expressed or implied, to viaticate the policy, the viatical settlement provider shall give written notice to the insurer that issued that insurance policy that the policy has or will become a viaticated policy.

(3) The viatical provider or viatical settlement broker shall deliver a request for verification of coverage to the insurer that issued the life policy that is the subject of the viatical transaction. The NAIC's form for verification shall be used unless standards for verification are developed by the commissioner.

(4) The insurer shall respond to a request for verification of coverage submitted on an approved form by a viatical settlement provider or viatical settlement broker within thirty calendar days of the date the request is received and shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract.

(5) Prior to or at the time of execution of the viatical settlement contract, the viatical settlement provider shall obtain a witnessed document in which the viator consents to the viatical settlement contract, represents that the viator has a full and complete understanding of the viatical settlement contract, that he or she has a full and complete understanding of the benefits of the life insurance policy, acknowledges that he or she is entering into the viatical settlement contract freely and voluntarily, and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the life insurance policy was issued.

(6) If a viatical settlement broker performs any of these activities required of the viatical settlement provider, the provider is deemed to have fulfilled the requirements of this Section.

B. All medical information solicited or obtained by any licensee shall be subject to the applicable provisions of state law relating to confidentiality of medical information.

C. All viatical settlement contracts entered into in this state shall provide the viator with an unconditional right to rescind the contract for at least fifteen calendar days from the receipt of the viatical settlement proceeds. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to repayment to the viatical settlement provider or purchaser of all viatical settlement proceeds and any premiums, loans, and loan interest that have been paid by the viatical settlement provider or purchaser.

D. The purchaser shall have the right to rescind a viatical settlement purchase agreement within three days after the disclosures mandated by R.S. 22:194(D) and (E) are received by the purchaser.

E. The viatical settlement provider shall instruct the viator to send the executed documents required to effect the change in ownership, assignment, or change in beneficiary directly to the independent escrow agent. Within three business days after the date the escrow agent receives the document (or from the date the viatical settlement provider receives the documents, if the viator erroneously provides the documents directly to the provider), the provider shall pay or transfer the proceeds of the viatical settlement into an escrow or trust account maintained in a state or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). Upon payment of the settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership, assignment, or change in beneficiary forms to the viatical settlement provider or related provider trust. Upon the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership, assignment, or designation of beneficiary from the insurance company, the escrow agent shall pay the settlement proceeds to the viator.

F. Failure to tender consideration to the viator for the viatical settlement contract within the time disclosed pursuant to R.S. 22:194(A)(6) renders the viatical settlement contract voidable by the viator for lack of consideration until the time consideration is tendered to and accepted by the viator.

G. Contacts with the insured for the purpose of determining the health status of the insured by the viatical settlement provider or viatical settlement broker after the viatical settlement has occurred shall only be made by the viatical settlement provider or broker licensed in this state or its authorized representatives and shall be limited to once every three months for insureds with a life expectancy of more than one year, and to no more than once per month for insureds with a life expectancy of one year or less. The provider or broker shall explain the procedure for these contacts at the time the viatical settlement contract is entered into. The limitations set forth in this Subsection shall not apply to any contacts with an insured for reasons other than determining the insured's health status. Viatical settlement providers and viatical settlement brokers shall be responsible for the actions of their authorized representatives.

Acts 2003, No. 343, §1.

§195. Prohibited practices

It is a violation of this Part for any person to enter into a viatical settlement contract within a two-year period commencing with the date of issuance of the insurance policy or certificate unless the viator certifies to the viatical settlement provider that one or more of the following conditions have been met within the two-year period:

(1) The policy was issued upon the viator's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least twenty-four months. The time covered under a group policy shall be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship;

(2) The viator is a charitable organization exempt from taxation under 26 U.S.C. 501(c)(3);

(3) The viator is not a natural person;

(4)(a) The viator submits independent evidence to the viatical settlement provider that one or more of the following conditions have been met within the two-year period:

(i) The viator or insured is terminally or chronically ill;

(ii) The viator's spouse dies;

(iii) The viator divorces his or her spouse;

(iv) The viator retires from full-time employment;

(v) The viator becomes physically or mentally disabled and a physician determines that the disability prevents the viator from maintaining full-time employment;

(vi) The viator was the insured's employer at the time the policy or certificate was issued and the employment relationship terminated;

(vii) A final order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor of the viator, adjudicating the viator bankrupt or insolvent or approving a petition seeking reorganization of the viator or appointing a receiver, trustee, or liquidator to all or a substantial part of the viator's assets;

(viii) The viator experiences a significant decrease in income that is unexpected and that impairs the viator's reasonable ability to pay the policy premium; or

(ix) The viator or insured disposes of his or her ownership interests in a closely held corporation.

(b) Copies of the independent evidence described in Paragraph (1) of this Subsection and documents required by R.S. 22:194.1(A) shall be submitted to the insurer when the viatical settlement provider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the viatical settlement provider that the copies are true and correct copies of the documents received by the viatical settlement provider.

(5) If the viatical settlement provider submits to the insurer a copy of the owner or insured's certification described in Paragraph (4) of this Section when the provider submits a request to the insurer to effect the transfer of the policy or certificate to the viatical settlement provider, the copy shall be deemed to conclusively establish that the viatical settlement contract satisfies the requirements of this Section and the insurer shall timely respond to the request.

Acts 2003, No. 343, §1.

§196. Advertising for viatical settlements and viatical settlements purchase agreements

A. The purpose of this Section is to provide prospective viators and viatical settlement purchasers with clear and unambiguous statements in the advertisement of viatical settlements and to assure the clear, truthful, and adequate disclosure of the benefits, risks, limitations, and exclusions of any viatical settlement contract or viatical settlement purchase agreement bought or sold. This purpose is intended to be accomplished by the establishment of guidelines and standards of permissible and impermissible conduct in the advertising of viatical settlements to assure that product descriptions are presented in a manner that prevents unfair, deceptive, or misleading advertising and is conducive to accurate presentation and description of viatical settlements through the advertising media and material used by viatical settlement licensees.

B. This Section shall apply to any advertising of viatical settlement contracts, viatical purchase agreements, or related products or services intended for dissemination in this state, including internet advertising viewed by persons located in this state. Where disclosure requirements are established pursuant to federal regulation, this Section shall be interpreted so as to minimize or eliminate conflict with federal regulation wherever possible.

C. Every viatical settlement licensee shall establish and at all times maintain a system of control over the content, form, and method of dissemination of all advertisements of its contracts, products, and services. All advertisements, regardless of by whom written, created, designed, or presented, shall be the responsibility of the viatical settlement licensee, as well as the individual who created or presented the advertisement. A system of control shall include regular routine notification, at least once a year, to agents and others authorized by the viatical settlement licensee who disseminate advertisements of the requirements and procedures for approval prior to the use of any advertisements not furnished by the viatical settlement licensee.

D. Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a viatical settlement contract or viatical settlement purchase agreement, product, or service shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

E. Certain viatical settlement advertisements are deemed false and misleading on their face and are prohibited. False and misleading viatical settlement advertisements include but are not limited to the following representations:

(1) "Guaranteed", "fully secured", "100 percent secured", "fully insured", "secure", "safe", "backed by rated insurance companies", "backed by federal law", "backed by state law", "state guaranty funds", or similar representations;

(2) "No risk", "minimal risk", "low risk", "no speculation", "no fluctuation", or similar representations;

(3) "Qualified or approved for individual retirement accounts (IRAs), Roth IRAs, 401(k) plans, simplified employee pensions (SEP), 403(b), Keogh plans, TSA, other retirement account rollovers", "tax deferred", or similar representations;

(4) Utilization of the word "guaranteed" to describe the fixed return, annual return, principal, earnings, profits, investment, or similar representations;

(5) "No sales charges or fees" or similar representations;

(6) "High yield", "superior return", "excellent return", "high return", "quick profit", or similar representations;

(7) Purported favorable representations or testimonials about the benefits of viatical settlement contracts or viatical settlement purchase agreements as an investment, taken out of context from newspapers, trade papers, journals, radio and television programs, and all other forms of print and electronic media.

F.(1) The information required to be disclosed under this Section shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

(2) An advertisement shall not omit material information or use words, phrases, statements, references, or illustrations if the omission or use has the capacity, tendency, or effect of misleading or deceiving viators, purchasers, or prospective purchasers as to the nature or extent of any benefit, loss covered, premium payable, or state or federal tax consequence. The fact that the viatical settlement contract or viatical settlement purchase agreement offered is made available for inspection prior to consummation of the sale, or an offer is made to refund the payment if the viator is not satisfied or that the viatical settlement contract or viatical settlement purchase agreement includes a "free look" period that satisfies or exceeds legal requirements, does not remedy misleading statements.

(3) An advertisement shall not use the name or title of a life insurance company or a life insurance policy unless the advertisement has been approved by the insurer.

(4) An advertisement shall not represent that premium payments will not be required to be paid on the life insurance policy that is the subject of a viatical settlement contract or viatical settlement purchase agreement in order to maintain that policy, unless that is the fact.

(5) An advertisement shall not state or imply that interest charged on an accelerated death benefit or a policy loan is unfair, inequitable, or in any manner an incorrect or improper practice.

(6) The words "free", "no cost", "without cost", "no additional cost", "at no extra cost", or words of similar import shall not be used with respect to any benefit or service unless true. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the payment or use other appropriate language.

(7)(a) Testimonials, appraisals, or analysis used in advertisements must be genuine; represent the current opinion of the author; be applicable to the viatical settlement contract or viatical settlement purchase agreement, product, or service advertised, if any; and be accurately reproduced with sufficient completeness to avoid misleading or deceiving prospective viators or purchasers as to the nature or scope of the testimonials, appraisal, analysis, or endorsement. In using testimonials, appraisals, or analysis, the viatical settlement licensee makes as its own all the statements contained therein, and the statements are subject to all the provisions of this Section.

(b) If the individual making a testimonial, appraisal, analysis, or an endorsement has a financial interest in the viatical settlement provider or related entity as a stockholder, director, officer, employee, or otherwise, or receives any benefit directly or indirectly other than required union scale wages, that fact shall be prominently disclosed in the advertisement.

(c) An advertisement shall not state or imply that a viatical settlement contract or viatical settlement purchase agreement, benefit, or service has been approved or endorsed by a group of individuals, society, association, or other organization unless that is the fact and unless any relationship between an organization and the viatical settlement licensee is disclosed. If the entity making the endorsement or testimonial is owned, controlled, or managed by the viatical settlement licensee, or receives any payment or other consideration from the viatical settlement licensee for making an endorsement or testimonial, that fact shall be disclosed in the advertisement.

(d) When an endorsement refers to benefits received under a viatical settlement contract or viatical settlement purchase agreement, all pertinent information shall be retained for a period of five years after its use.

G. An advertisement shall not contain statistical information unless it accurately reflects recent and relevant facts. The source of all statistics used in an advertisement shall be identified.

H. An advertisement shall not disparage insurers, viatical settlement providers, viatical settlement brokers, viatical settlement investment agents, insurance producers, policies, services, or methods of marketing.

I. The name of the viatical settlement licensee shall be clearly identified in all advertisements about the licensee or its viatical settlement contract or viatical settlement purchase agreements, products, or services, and if any specific viatical settlement contract or viatical settlement purchase agreement is advertised, the viatical settlement contract or viatical settlement purchase agreement shall be identified either by form number or some other appropriate description. If an application is part of the advertisement, the name of the viatical settlement provider shall be shown on the application.

J. An advertisement shall not use a trade name, group designation, name of the parent company of a viatical settlement licensee, name of a particular division of the viatical settlement licensee, service mark, slogan, symbol, or other device or reference without disclosing the name of the viatical settlement licensee, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the viatical settlement licensee, or to create the impression that a company other than the viatical settlement licensee would have any responsibility for the financial obligation under a viatical settlement contract or viatical settlement purchase agreement.

K. An advertisement shall not use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color, or other characteristics are so similar to a combination of words, symbols, or physical materials used by a government program or agency or otherwise appear to be of such a nature that they tend to mislead prospective viators or purchasers into believing that the solicitation is in some manner connected with a government program or agency.

L. An advertisement may state that a viatical settlement licensee is licensed in the state where the advertisement appears, provided it does not exaggerate that fact or suggest or imply that competing viatical settlement licensee may not be so licensed. The advertisement may ask the audience to consult the licensee's web site or contact the Department of Insurance to find out if the state requires licensing and, if so, whether the viatical settlement provider, viatical settlement broker, or viatical settlement investment agent is licensed.

M. An advertisement shall not create the impression that the viatical settlement provider, its financial condition or status, the payment of its claims, or the merits, desirability, or advisability of its viatical settlement contracts or viatical settlement purchase agreement forms are recommended or endorsed by any government entity.

N. The name of the actual licensee shall be stated in all of its advertisements. An advertisement shall not use a trade name, any group designation, name of any affiliate or controlling entity of the licensee, service mark, slogan, symbol, or other device in a manner that would have the capacity or tendency to mislead or deceive as to the true identity of the actual licensee or create the false impression that an affiliate or controlling entity would have any responsibility for the financial obligation of the licensee.

O. An advertisement shall not directly or indirectly create the impression that any division or agency of the state or of the United States government endorses, approves, or favors:

(1) Any viatical settlement licensee or its business practices or methods of operation;

(2) The merits, desirability, or advisability of any viatical settlement contract or viatical settlement purchase agreement;

(3) Any viatical settlement contract or viatical settlement purchase agreement; or

(4) Any life insurance policy or life insurance company.

P. If the advertiser emphasizes the speed with which the viatication will occur, the advertising must disclose the average time frame from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator.

Q. If the advertising emphasizes the dollar amounts available to viators, the advertising shall disclose the average purchase price as a percent of face value obtained by viators contracting with the licensee during the past six months.

Acts 2003, No. 343, §1.

§197. Fraud prevention and control

A. Fraudulent viatical settlement acts, interference, and participation of convicted felons prohibited. (1) A person shall not commit a fraudulent viatical settlement act.

(2) A person shall not knowingly or intentionally interfere with the enforcement of the provisions of this Part or investigations of suspected or actual violations of this Part.

(3) A person in the business of viatical settlements shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of viatical settlements.

B. Fraud warning required. (1) Viatical settlements contracts and purchase agreement forms and applications for viatical settlements, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

"Any person who knowingly presents false information in an application for insurance or viatical settlement contract or a viatical settlement purchase agreement is guilty of a crime and may be subject to fines and confinement in prison."

(2) The lack of a statement as required in Paragraph (1) of this Subsection does not constitute a defense in any prosecution for a fraudulent viatical settlement act.

C. Mandatory reporting of fraudulent viatical settlement acts.

(1) Any person engaged in the business of viatical settlements having knowledge or a reasonable belief that a fraudulent viatical settlement act is being, will be, or has been committed shall provide to the commissioner the information required by, and in a manner prescribed by, the commissioner.

(2) Any other person having knowledge or a reasonable belief that a fraudulent viatical settlement act is being, will be, or has been committed may provide to the commissioner the information required by, and in a manner prescribed by, the commissioner.

D. Immunity from liability. (1) No civil liability shall be imposed on and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated, or completed fraudulent viatical settlement acts or suspected or completed fraudulent insurance acts, if the information is provided to or received from:

(a) The commissioner or the commissioner's employees, agents, or representatives;

(b) Federal, state, or local law enforcement or regulatory officials or their employees, agents, or representatives;

(c) A person involved in the prevention and detection of fraudulent viatical settlement acts or that person's agents, employees, or representatives;

(d) The National Association of Insurance Commissioners (NAIC), National Association of Securities Dealers (NASD), the North American Securities Administrators Association (NASAA), or their employees, agents, or representatives, or other regulatory body overseeing life insurance, viatical settlements, securities, or investment fraud; or

(e) The life insurer that issued the life insurance policy covering the life of the insured.

(2) Paragraph (1) of this Subsection shall not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent viatical settlement act or a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that Paragraph (1) of this Subsection does not apply because the person filing the report or furnishing the information did so with actual malice.

(3) A person identified in Paragraph (1) of this Subsection shall be entitled to an award of attorney fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this Act and the party bringing the action was not substantially justified in doing so. For purposes of this Section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

(4) This Section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in Paragraph (1) of this Subsection.

E. Confidentiality. (1) The documents and evidence provided pursuant to Subsection D of this Section or obtained by the commissioner in an investigation of suspected or actual fraudulent viatical settlement acts shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

(2) Paragraph (1) of this Subsection does not prohibit release by the commissioner of documents and evidence obtained in an investigation of suspected or actual fraudulent viatical settlement acts:

(a) In administrative or judicial proceedings to enforce laws administered by the commissioner;

(b) To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent viatical settlement acts, or to the NAIC; or

(c) At the discretion of the commissioner, to a person in the business of viatical settlements that is aggrieved by a fraudulent viatical settlement act.

(3) Release of documents and evidence under Paragraph (2) of this Subsection does not abrogate or modify the privilege granted in Paragraph (1).

F. Other law enforcement or regulatory authority. This Part shall not:

(1) Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;

(2) Prevent or prohibit a person from disclosing voluntarily information concerning viatical settlement fraud to a law enforcement or regulatory agency other than the insurance department; or

(3) Limit the powers granted elsewhere by the laws of this state to the commissioner or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

G. Viatical settlement antifraud initiatives. Viatical settlement providers and viatical settlement brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent viatical settlement acts. At the discretion of the commissioner, the commissioner may order, or a licensee may request and the commissioner may grant, such modifications of the following required initiatives as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications may reasonably be expected to accomplish the purpose of this Section. Antifraud initiatives shall include:

(1) Fraud investigators, who may be viatical settlement provider or viatical settlement broker employees or independent contractors; and

(2) An antifraud plan, which shall be submitted to the commissioner. The antifraud plan shall include but not be limited to:

(a) A description of the procedures for detecting and investigating possible fraudulent viatical settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(b) A description of the procedures for reporting possible fraudulent viatical settlement acts to the commissioner;

(c) A description of the plan for antifraud education and training of underwriters and other personnel; and

(d) A description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent viatical settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

(3) Antifraud plans submitted to the commissioner shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

Acts 2003, No. 343, §1.

§198. Injunctions; civil remedies; cease and desist

A. In addition to the penalties and other enforcement provisions of this Part, if any person violates this Part or any regulation implementing this Part, the commissioner may seek an injunction in a court of competent jurisdiction and may apply for temporary and permanent orders that the commissioner determines are necessary to restrain the person from committing the violation.

B. Any person damaged by the acts of a person in violation of this Part may bring a civil action against the person committing the violation in a court of competent jurisdiction.

C. A violation of this Part attendant to the execution of a viatical settlement purchase agreement renders the viatical settlement purchase agreement voidable and subject to rescission by the viatical settlement purchaser, upon return of the policy received to the viatical settlement provider. Suit for rescission may be brought in a court of competent jurisdiction or where the alleged violator resides or has a principal place of business or where the alleged violation occurred.

D. The commissioner may issue a cease and desist order upon a person that violates any provision of this Part, any regulation or order adopted by the commissioner, or any written agreement entered into with the commissioner.

E. When the commissioner finds that an activity in violation of this Part presents an immediate danger to the public that requires an immediate final order, the commissioner may issue an emergency cease and desist order reciting with particularity the facts underlying the findings. The emergency cease and desist order is effective immediately upon service of a copy of the order on the respondent and remains effective for ninety days. If the commissioner begins nonemergency cease and desist proceedings, the emergency cease and desist order remains effective, absent an order by a court of competent jurisdiction pursuant to Part XXIX of this Chapter.

Acts 2003, No. 343, §1.

§199. Unfair trade practices

A violation of this Part shall be considered an unfair trade practice under Part XXVI of this Chapter subject to the penalties contained in that Part.

Acts 2003, No. 343, §1.

§200. Authority to adopt regulations

The commissioner shall have the authority to:

(1) Adopt regulations implementing this Part in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.;

(2) Establish standards for evaluating reasonableness of payments under viatical settlement contracts for persons who are terminally or chronically ill. This authority includes but is not limited to regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a life insurance policy;

(3) Establish appropriate licensing requirements and standards for continued licensure for viatical settlement providers, brokers, and investment agents;

(4) Require a bond or other mechanism for financial accountability for viatical settlement providers and brokers; and

(5) Adopt rules governing the relationship and responsibilities of both insurers and viatical settlement providers, viatical settlement brokers, and viatical settlement investment agents during the viatication of a life insurance policy or certificate.

Acts 2003, No. 343, §1.

PART V-B. VIATICAL SETTLEMENTS

§201. REPEALED BY ACTS 2003, No. 343, §3.
§202. REPEALED BY ACTS 2003, No. 343, §3.
§203. REPEALED BY ACTS 2003, No. 343, §3.
§204. REPEALED BY ACTS 2003, No. 343, §3.
§205. REPEALED BY ACTS 2003, No. 343, §3.
§206. REPEALED BY ACTS 2003, No. 343, §3.
§207. REPEALED BY ACTS 2003, No. 343, §3.
§208. REPEALED BY ACTS 2003, No. 343, §3.
§209. REPEALED BY ACTS 2003, No. 343, §3.
§210. REPEALED BY ACTS 2003, No. 343, §3.
§210.1. REPEALED BY ACTS 2003, No. 343, §3.

PART VI. HEALTH AND ACCIDENT INSURANCE

§211. Approval and disapproval of forms; filing of rates

A. No policy of health and accident insurance shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application which becomes a part of any such policy be used in connection therewith until a copy of the form and of the premium rates and of the classifications of risks pertaining thereto have been filed with the commissioner of insurance; nor shall any such policy, endorsement, rider, or application be so used until the expiration of thirty days after the form has been filed unless the commissioner of insurance shall sooner give his written approval thereto. The commissioner of insurance shall notify in writing the insurer which has filed any such form if it does not comply with the provisions of this part, specifying the reasons for his opinion; and it shall thereafter be unlawful for such insurer to issue such form in this state. In such notice, the commissioner of insurance shall state that a hearing will be granted within twenty days upon written request of the insurer.

B. The commissioner of insurance may at any time, after a hearing of which not less than twenty days written notice shall have been given to the insurer, withdraw his approval of any such form on any of the grounds stated in this Section. It shall be unlawful for the insurer to issue such form or use it in connection with any policy after the effective date of such withdrawal of approval. The notice of any hearing called under this Sub-section shall specify the matters to be considered at such hearing and any decision affirming disapproval or directing withdrawal of approval under this Section shall be in writing and shall specify the reasons therefor.

C. The commissioner of insurance shall not disapprove or withdraw approval of any such policy on the ground that its provisions do not comply with R.S. 22:213 or on the ground that it is not printed in uniform type if it shall be shown that the rights of the insured or the beneficiary under the policy as a whole are not less favorable than the rights provided by R.S. 22:213 and that the provisions or type size used in the policy are required in the state, district or territory of the United States in which the insurer is organized, anything in this part to the contrary notwithstanding.

Acts 1958, No. 125.

§212. Form of policy

No such policy or contract shall be delivered or issued for delivery on risks in this state unless:

(1) The entire money and other consideration therefor are expressed therein; and

(2) The time at which the insurance takes effect and terminates is expressed therein; and

(3) It purports to insure only one person except as hereinafter specifically provided in this Part; and

(4) Every printed portion of the text matter of the policy and of any endorsements or attached papers is printed in type the size of which shall be uniform and the face of which shall be not less than ten point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, captions and sub-captions and form numbers); and

(5) The exceptions and reductions of indemnity are clearly set forth in the policy or contract and are printed, at the insurer's option, either with the benefit to which they apply or under an appropriate caption such as, "Exceptions" or "Exceptions and Reductions"; and

(6) Each such form, including riders and endorsements, shall be identified by a form number in the lower left hand corner of the first page thereof.

(7)(a) There is prominently printed thereon or attached thereto, a notice to the insured that ten days are allowed, from the date of his receipt of the policy, to examine its provisions and if such policy was solicited by deceptive advertising or negotiated by deceptive, misleading, or untrue statements of the insurer or any agent in behalf of the insurer, such policy may be surrendered within said ten-day period and any premium advanced by the insured, upon such surrender, shall be immediately returned to him; provided, that the insurer shall have the option of printing or attaching the notice above required or a notice of equal prominence which, in the opinion of the commissioner of insurance, is not less favorable to the policyholder, and provided further that this Paragraph (7) shall not apply to trip-travel insurance policies which by their terms are not renewable.

(b) If the policy is delivered by an agent or broker, a receipt shall be signed by the policyholder acknowledging delivery of the policy. The receipt shall include the policy number and the date the delivery was completed. All delivery receipts required by this Subparagraph shall be retained by the insurer, its agent, or the broker for two consecutive years. The requirement of this Subparagraph shall not apply to any insurer that markets under a home service marketing distribution method and that issues a majority of its policies on a weekly or monthly basis.

(c) If the policy is delivered by mail, it shall be sent by certified mail, return receipt requested, or a certificate of mailing shall be obtained showing the date the policy was mailed to the policyholder. For policy issuances verified by a certificate of mailing, it is presumed that the policy is received by the policyholder ten days from the date of mailing. The receipts and the certificate of mailing described in this Subparagraph shall be retained by the insurer or agent for three years. In addition, the insurer or agent may utilize commercial carriers or other commercially recognized carriers to deliver the policy to the policyholder; however, the insurer or agent shall maintain documentation of actual delivery of such policy for three years. The policy or certificate of insurance may also be delivered electronically to the policyholder or insured in accordance with R.S. 9:2608; however, the insurer and the policyholder or insured shall agree electronically to such electronic delivery, and documentation of such delivery shall be maintained by the insurer for three years.

(8) In any case where the policy is subject to cancellation or renewal at the option of the insurer, there shall be prominently printed on the first page of such policy a statement so informing the policyholder.

Acts 1958, No. 125. Amended by Acts 1960, No. 170, §1; Acts 1993, No. 141, §1; Acts 2003, No. 858, §1.

§213. Health and accident policy provisions

A. Required provisions. Each such policy shall contain in substance the following provisions or, at the option of the insurer, provisions which in the opinion of the commissioner of insurance are not less favorable to the policyholder; provided that, except as permitted by R.S. 22:211(C), no time limitation with respect to the filing of notice or proof of loss or within which suit may be brought upon the policy shall differ from the time limitations of the following provisions:

(1) Entire contract: Changes: This policy, including the endorsements and the attached papers, if any, and in case of industrial insurance, the written application, constitutes the entire contract of insurance. No agent has authority to change this policy or to waive any of its provisions. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto.

(2) Reinstatement: If default be made in the payment of any agreed premium for this policy, the subsequent acceptance of such defaulted premium by the insurer or by any agent authorized by the insurer to accept such premium, shall reinstate the policy, but the reinstated policy shall cover only loss resulting from accidental injury thereafter sustained or loss due to sickness beginning more than ten days after the date of such acceptance.

(3) Notice of claim: Written notice of claim for injury or for sickness must be given to the insurer within twenty days after the date of the accident causing such injury or the commencement of the disability from such sickness, except that in case of industrial policies such notice of claim must be given to the insurer within ten days in such cases. In the event of accidental death, immediate notice thereof must be given to the insurer. Such notice given by or on behalf of the insured or the beneficiary to the insurer at (insert the location of such office as the insurer may designate for that purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. Failure to give such notice within such time shall not invalidate nor reduce any claim if it was not reasonably possible to give such notice within the time required, provided written notice of claim is given as soon as reasonably possible. (In this paragraph the requirement relating to immediate notice of claim in event of accidental death may be omitted at the option of the insurer.)

(4) Claim forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, affirmative written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(5) Proofs of loss: Affirmative written proof of loss must be furnished to the insurer at its said office in case of claim for loss of time from disability within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event later than one year from the time proof is otherwise required. Any such policy may also provide, at the insurer's option that written notice or proof of continuance of disability must be furnished not less frequently than each ninety days during the continuance of disability.

(6) Time of payment of claims: Indemnities payable under this policy for any loss other than loss of time on account of disability will be paid immediately upon receipt of written proof of such loss. Subject to written proof of loss accrued indemnities for loss of time on account of disability will be paid (insert period of payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately.

(7) Payment of claims: Indemnity for loss of life and any other accrued indemnities unpaid at the insured's death will be paid to the beneficiary, if surviving the insured, and otherwise to the estate of the insured. All other indemnities will be paid to the insured. The policy may, at the insurer's option, provide that if there is no beneficiary, or the beneficiary is the estate of the insured, or the insured or beneficiary is a minor or not competent to give a valid release, the insurer may pay any amount not exceeding one thousand dollars, otherwise payable to the insured or his estate to any relative by blood or connection by marriage of the insured appearing to the insurer to be equitably entitled thereto, and may make payment of any amount not exceeding one thousand dollars, otherwise payable to the beneficiary to any relative by blood or connection by marriage of such beneficiary appearing to the insurer to be equitably entitled thereto. The policy may, at the insurer's option, also provide that all or a portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may be paid directly to the hospital or person rendering such services; but the policy may not require that the services be rendered by a particular hospital or person.

(8) Physical examinations: The insurer shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(9) Cancellation by insured: If the insured shall at any time change his occupation to one classified by the insurer as less hazardous than that stated in the policy, the insurer, upon written request of the insured, and at the insured's option, will either cancel the policy upon its surrender and refund the unearned premium or will reduce the premium rate accordingly and refund the excess pro rata unearned premium from the date of receipt of proof of such change of occupation.

(10) Consent of beneficiary: Consent of the beneficiary shall not be requisite to surrender or assignment of this policy, nor to change of beneficiary, nor to any other changes in this policy.

(11) Legal action: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after proofs of loss have been filed in accordance with the requirements of this policy. No such action shall be brought after the expiration of one year after the time proofs of loss are required to be filed.

(12) Extension of time limitations: If any limitation of this policy with respect to giving notice of claim, furnishing proof of loss, or bringing any action on this policy is less than that permitted by law of the state, district or territory in which the insured resides at the time this policy is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

(13) Time Limit on Certain Defenses: (a) After three years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such three year period. The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial three year period, nor to limit the application of provisions (B), (1), (2), (3), and (4) of this Section in the event of misstatement with respect to age or occupation or other insurance.

A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50, or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE":

After this policy has been in force for a period of three years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(b) No claim for loss incurred or disability (as defined in the policy) commencing after three years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(14) Uniform claim forms: Notwithstanding any other law to the contrary, including Paragraph (4) of this Subsection, all claims shall be processed in conformity with the uniform claim form issued by the Department of Insurance pursuant to R.S. 22:11.

B. Other provisions (optional). No such policy shall be delivered or issued for delivery containing provisions respecting the matters set forth below unless such provisions are, in substance, in the following forms, or, at the option of the insurer, in forms which in the written opinion of the commissioner of insurance are not less favorable to the policyholder:

(1) Change of occupation: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss.

(2) Misstatement of age: If the age of the insured has been misstated, any amount payable or any indemnity accruing under this policy shall be such as the premium paid would have purchased at the correct age. If because of a misstatement of age this policy was issued at an age or was continued or renewed beyond an age at which it would not have been issued, continued or renewed under the insurer's underwriting rules in effect at the date of issue, the amount payable hereunder on account of loss occurring after such age, shall be limited to a return of the premiums paid thereafter.

(3) Other insurance in this insurer: If a like policy or policies previously issued by this insurer to the insured be in force concurrently herewith, making the aggregate indemnity for (insert type of coverage) in excess of (insert maximum limit of indemnity) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.

or, in lieu thereof:

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to one such policy, and the insurer will return to the insured or to his estate all premiums paid for such policies in excess thereof.

(4) Insurance with other insurers: If the insured carry with one or more insurers other valid insurance covering the same loss without having given written notice thereof to this insurer prior to the occurrence of loss, the only liability under this policy shall be for such proportion of the indemnities otherwise provided hereunder as the indemnities of which the insurer had notice (include the indemnities under this policy) bear to the total amount of like indemnities in all policies covering such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined.

(5) Relation of earnings to insurance: If the total monthly amount of loss of time indemnities promised in all policies or certificates of accident, health, or disability insurance upon the insured, whether payable on a weekly or monthly basis, shall exceed the average monthly earnings of the insured at the time disability commenced or for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of the indemnities specified in the policy as the amount of such monthly earnings of the insured bears to the total amount of monthly indemnities promised under all such policies or certificates upon the insured at the time of such disability and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the indemnities actually paid hereunder; but this shall not operate to reduce the total monthly amount of indemnities payable under all such policies or certificates upon the insured below the sum of one hundred dollars or the sum of the monthly indemnities specified in such policies or certificates, whichever is the lesser.

(6) Unpaid premium: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(7) Cancellation: The insurer may cancel this policy at any time subject to the provisions of R.S. 22:228. Such cancellation shall be by written notice, delivered to the insured, or mailed to his last address as shown by the records of the insurer, shall refund the pro rata unearned portion of any premium paid, and shall comply with the provisions of R.S. 22:636(F). Such cancellation shall be without prejudice to any claim for benefits accrued or expenses incurred for services rendered prior to cancellation. Benefits and expenses incurred shall be as defined and limited by the terms of the policy. The insured may likewise cancel this policy on the above terms. Upon cancellation by the insurer, however, the insurer shall only be liable for any claim for benefits accrued, or for expenses incurred for services rendered, subsequent to the cancellation date if the subsequent claim is for an illness or condition which was the basis of any claim prior to cancellation and for which the insurer had notice and if the policy of insurance is cancelled for reasons other than failure of the policyholder to pay premiums or failure of the insured to maintain eligibility as provided in the policy. Upon the written request of the named insured, the insurer shall provide to the insured in writing the reasons for cancellation of the policy. There shall be no liability on the part of and no cause of action of any nature shall arise against any insurer or its agents, employees, or representatives for any action taken by them to provide the reasons for cancellation as required by this Paragraph.

(8) Conformity with state statutes: Any provision of this policy which, on the date of issue, is in conflict with the statutes of the state in which the insured resides at the date of issue is understood to be amended to conform to such statutes.

(9) Illegal occupation: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

(10) Intoxicants and narcotics: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of narcotics unless administered on the advice of a physician.

C. If any provision of this Section is inapplicable to or is inconsistent with any risk covered by a particular form of policy the insurer may, subject to the approval of the commissioner of insurance, omit from such policy such inapplicable provision or modify such inconsistent provision in such manner as to make it consistent with the coverage provided by the policy.

D. REPEALED BY ACTS 1995, No. 730, §1.

Acts 1958, No. 125. Amended by Acts 1958, No. 97, §1; Acts 1982, No. 760, §1; Acts 1985, No. 249, §1; Acts 1987, No. 510, §1; Acts 1989, No. 269, §1; Acts 1989, No. 426, §1; Acts 1990, No. 886, §2; Acts 1991, No. 777, §1, eff. Sept. 30, 1991; Acts 1993, No. 57, §1; Acts 1993, No. 653, §1; Acts 1995, No. 730, §1.

§213.1. Prohibition of discrimination against dental care services

A. Whenever the terms "physician", "surgeon", "medical doctor", or any other terms which refer to licensed practitioners of the healing arts are used in any health and accident insurance policy, group health and accident insurance policy, certificate of insurance, contract providing coverage for hospital service, medical or surgical benefits as set out in R.S. 22:1661, miscellaneous insurance contract authorized by R.S. 22:6(14) which provides benefits for hospital and medical care, public employee group benefit program document, subscriber contract providing health care treatment coverage, or any other policy, contract, or document providing for the payment of health care treatment procedures which are specified in the policy, contract, or document and are within the scope of a dentist's professional license, such terms shall be construed to include a dentist, licensed under the laws of the state of Louisiana governing the practice of dentistry under Chapter 9, Title 37, Louisiana Revised Statutes of 1950, who performs such specified treatment procedures.

B. Payment shall not be denied for a service provided by a person licensed to engage in the practice of dentistry if that service would be a covered service if provided by a person licensed to engage in the practice of medicine and surgery, if the service can be lawfully performed within the scope of a person's license to practice dentistry.

C. The provisions of this Section shall be applicable only with respect to policies, contracts, or other documents delivered, issued for delivery, promulgated, or renewed in this state on or after January 1, 1990.

D. This Section shall not be construed to mandate that any benefit or health care treatment be authorized and included in a policy, contract, or other document.

Added by Acts 1974, No. 544, §1; Acts 1989, No. 817, §1.

§213.2. Health and accident policy provisions; service charges; penalties

A. Any health and accident insurance policy issued under this Part or Part VI-A of this Title, and any health and accident insurance policy having effect in this state, shall provide coverage without regard to the insured's obligation of deductibles or copayments for the service charges assessed pursuant to R.S. 22:239. The service charges assessed to a patient pursuant to R.S. 22:239 shall be a mandated benefit of any health and accident insurance coverage issued by any insurer or insurance arrangement over and above any insurance policy limits, negotiated per diem, or managed care arrangement, except an insolvent insurer.

B. Each service charge for each patient admission shall be paid by the insurer or insurance arrangement in accordance with the plan of operation adopted pursuant to R.S. 22:235. Failure to pay each service charge for each patient according to this Section shall cause the insurer or insurance arrangement to be liable to the Louisiana Health Plan, the commissioner of insurance, or both, for an amount determined by the board, not to exceed five hundred dollars, plus interest. Any insurer or insurance arrangement found to have failed to comply with this Section as to each service charge for each patient admission on three or more occasions during a six-month period shall be liable for an amount determined by the board, no less than five hundred dollars and not to exceed one thousand five hundred dollars per failure to pay each service charge for each patient admission, together with attorney fees, interest, and court costs. The Louisiana Health Plan, the commissioner, or both, are specifically authorized to conduct audits of insurers or insurance arrangements in order to enforce compliance with this Section.

C. For the purposes of this Section, insurance or insurance arrangement also includes any policy or plan of insurance or of self-insurance which provides payment, indemnity, or reimbursement for charges resulting from accident, injury, or illness when an employer, insurer, or tortfeasor is responsible for those charges.

D. For the purposes of this Section, insurance or insurance arrangement shall not include the State Employees Group Benefit Program.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1991, No. 574, §1, eff. July 16, 1991; Acts 1993, No. 191, §1.

{{**NOTE***:* ACTS 1990, NO. 131, §3, PROVIDES ADDITIONAL DATES FOR IMPOSITION OF SERVICE CHARGES AND AUTHORITY TO ISSUE POLICIES.}}

§213.3. Cancellation by insurer and grace period; individual health and accident policies

Whenever an insurer which issues an individual accident and health policy does not receive a premium payment fifteen days prior to the end of the grace period, the insurer shall mail, by first class mail, a notice to the policyholder. The notice shall state that if the premium has not been paid by the end of the grace period, the policy will lapse as provided by the provisions of the policy. The notice shall also state that the policy will be reinstated with no penalties whatsoever to the insured if the full premium payment is received within the period allowed for reinstatement. Nothing in this code shall mandate a separate lapse notice for nonpayment of premiums on a policy issued by an insurance company whose products are marketed on the home service distribution method and which issues a majority of these policies on a monthly or weekly basis.

Acts 1990, No. 886, §1.

§213.4. Additional sources; required coverage

A.(1) Notwithstanding any other provision of law, no hospital, health, or medical expense insurance policy, hospital or medical services contract, employee welfare benefit plan, health and accident insurance policy, or any other insurance contract of this type, including a group insurance or self-insurance plan, shall prohibit the receipt of payment under another such policy for any health care service covered under such other policy, provided that a policy may state that:

(a) Its deductible amount must be fully satisfied, either by the prior payment of a deductible under another policy in whole or in part or by partial payment of its deductible before any benefits are payable.

(b) No payment is required under any policy if the health care service in question is not covered by that policy.

(2) In no event shall the combined payment under multiple policies and federal or state government plans exceed one hundred percent of the charge for the provided health care service.

B. The provisions of this Section shall not apply to individually underwritten limited benefit and supplemental health insurance policies.

Acts 1992, No. 310, §1; Acts 1995, No. 593, §1.

§213.5. Dental reimbursement or payments

A. Every company that issues, delivers, amends, or renews a policy of dental insurance in this state providing coverage for dental health care treatment which provides that the payment of benefits under the policy shall be based upon the usual and customary fee charged by licensed dentists shall contain all of the following disclosure requirements:

(1) The frequency of the determination of the usual and customary fee.

(2) A specific and detailed description of the methodology used to determine the usual and customary fee.

(3) The percentile that determines the maximum benefit that the company will pay for each dental procedure, if the usual and customary fee is determined by taking a sample of fees submitted on actual claims from licensed dentists and then determining the benefit by selecting a percentile of those fees.

B. Each insurer providing dental health coverage shall, upon request, provide a complete copy of the dental health coverage provisions, including the information enumerated in Subsection A of this Section, to each insured. Every employee benefit explanation or description and any proposal for dental insurance coverage shall also contain such information regarding the determination of the usual and customary fee.

C. As used in this Section, the following definitions shall apply:

(1) "Usual fee" is the fee which an individual dentist most frequently charges for a specific dental procedure.

(2) "Customary fee" is the fee level determined by the administrator of the dental benefit plan from actual submitted fees for a specific dental procedure to establish the maximum benefit payable under a given plan for that specific procedure.

D. The disclosure must be provided upon request to all group and individual policyholders and group certificate holders. All proposals for dental insurance must notify the prospective policyholder that information regarding usual and customary fee determinations are available from the insurer. The employee benefit descriptions or supplemental documents must notify the employee that information regarding dental reimbursements rates are available from the employer.

Acts 1992, No. 329, §1.

§213.6. Prohibited discrimination; prenatal test results

A. No hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan, or any policy of group, family group, blanket, or association health and accident insurance, a self-insurance plan, health maintenance organization, and preferred provider organization, which delivers or issues for delivery in this state an insurance policy or plan shall, on the basis of any prenatal test result:

(1) Terminate, restrict, limit, or otherwise apply conditions to the coverage under the policy or plan, or restrict the sale of the policy or plan in force.

(2) Cancel or refuse to renew the coverage under the policy or plan in force.

(3) Deny coverage or exclude an individual or family member from coverage under the policy or plan in force.

(4) Impose a rider that excludes coverage for certain benefits or services under the policy or plan in force.

(5) Establish differentials in premium rates or cost sharing for coverage under the policy or plan in force.

(6) Otherwise discriminate against an individual or family member in the provision of insurance.

B. The provisions of this Section shall not apply to tests conducted to determine pregnancy.

Acts 1997, No. 1418, §1; Acts 2003, No. 129, §1, eff. May 28, 2003.

§213.7. Prohibited discrimination; genetic information; disclosure requirements; definitions

A. As used in this Section, the following terms shall have the following meanings:

(1) "Collection" means obtaining a DNA sample or samples.

(2) "Compulsory disclosure" means any disclosure of genetic information mandated or required by federal or state law in connection with a judicial, legislative, or administrative proceeding.

(3) "Disclose" means to convey or to provide access to genetic information to a person other than the individual.

(4) "DNA" means deoxyribonucleic acid including mitochondrial DNA, complementary DNA, as well as any DNA derived from ribonucleic acid (RNA).

(5) "Family" includes an individual's blood relatives and any legal relatives, including a spouse or adopted child, who may have a material interest in the genetic information of the individual.

(6) "Genetic characteristic" means any gene or chromosome, or alteration thereof, that is scientifically or medically believed to cause a disease, disorder, or syndrome, or to be associated with a statistically significant increased risk of development of a disease, disorder, or syndrome.

(7) "Genetic analysis" means the process of characterizing genetic information from a human tissue sample.

(8) "Genetic information" means all information about genes, gene products, inherited characteristics, or family history/pedigree that is expressed in common language.

(9) "Genetic test" means any test for determining the presence or absence of genetic characteristics in an individual, including tests of nucleic acids, such as DNA, RNA, and mitochondrial DNA, chromosomes, or proteins in order to diagnose or identify a genetic characteristic.

(10) "Individual" means the source of a human tissue sample from which a DNA sample is extracted or genetic information is characterized.

(11) "Individual identifier" means a name, address, social security number, health insurance identification number, or similar information by which the identity of an individual can be determined with reasonable accuracy, either directly or by reference to other available information. Such term does not include characters, numbers, or codes assigned to an individual or a DNA sample that cannot singly be used to identify an individual.

(12) "Insurer" means any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan, or any policy of group, family group, blanket, or association health and accident insurance, a self-insurance plan, health maintenance organization, and preferred provider organization, including insurance agents and third-party administrators, which delivers or issues for delivery in this state an insurance policy or plan.

(13) "Person" means all persons other than the individual who is the source of a tissue sample and shall include a family, corporation, partnership, association, joint venture, government, governmental subdivision or agency, and any other legal or commercial entity.

(14) "Research" means scientific investigation that includes systematic development and testing of hypotheses for the purpose of increasing knowledge.

(15) "Storage" means retention of a DNA sample or of genetic information for an extended period of time after the initial testing process.

B.(1) No insurer shall, on the basis of any genetic information concerning an individual or family member or on the basis of an individual's or family member's request for or receipt of genetic services, or the refusal to submit to a genetic test or make available the results of a genetic test:

(a) Terminate, restrict, limit, or otherwise apply conditions to the coverage of an individual or family member under the policy or plan, or restrict the sale of the policy or plan to an individual or family member.

(b) Cancel or refuse to renew the coverage of an individual or family member under the policy or plan.

(c) Deny coverage or exclude an individual or family member from coverage under the policy or plan.

(d) Impose a rider that excludes coverage for certain benefits or services under the policy or plan.

(e) Establish differentials in premium rates or cost sharing for coverage under the policy or plan.

(f) Otherwise discriminate against an individual or family member in the provision of insurance.

(2) No insurer shall require an applicant for coverage under the policy or plan, or an individual or family member who is presently covered under a policy or plan, to be the subject of a genetic test or to be subjected to questions relating to genetic information.

(3) All insurers shall, in the application or enrollment information provided by the insurer concerning a policy or plan, provide an applicant or enrollee with a written statement disclosing the rights of the applicant or enrollee under this Section. Such statement shall be in a form and manner that is noticeable to and understandable by an average applicant or enrollee.

C.(1) No insurer shall obtain genetic information from an insured or enrollee, or from their DNA sample, without first obtaining written informed consent from the insured, enrollee, or their representative.

(2) To be valid, an authorization for disclosure of genetic information shall:

(a) Be in writing, signed by the individual and dated on the date of such signature.

(b) Identify the person permitted to make the disclosure.

(c) Describe the specific genetic information to be disclosed.

(d) Identify the person to whom the information is to be disclosed.

(e) Describe with specificity the purpose for which the disclosure is being made.

(f) State the date upon which the authorization will expire, which in no event shall be more than sixty days after the date of the authorization.

(g) Include a statement that the authorization is subject to revocation at any time before the disclosure is actually made or the individual is made aware of the details of the genetic information.

(h) Include a statement that the authorization shall be invalid if used for any purpose other than the described purpose for which the disclosure is made.

(3) A copy of the authorization shall be provided to the individual.

(4) An individual may revoke or amend the authorization, in whole or in part, at any time.

(5) A general authorization for the release of medical records or medical information shall not be construed as an authorization for disclosure of genetic information. With respect to medical records that contain genetic information, the requirements for disclosure of genetic information under this Section must be complied with.

D. The requirements of this Section shall not apply to the genetic information obtained:

(1) By a state, parish, municipal, or federal law enforcement agency for the purposes of establishing the identity of a person in the course of a criminal investigation or prosecution.

(2) To determine paternity.

(3) To determine the identity of deceased individuals.

(4) For anonymous research where the identity of the subject will not be released.

(5) Pursuant to newborn screening requirements established by state or federal law.

(6) As authorized by federal law for the identification of persons.

(7) By the Department of Social Services or by a court having juvenile jurisdiction as set forth in Children's Code Article 302 for the purposes of child protection investigations or neglect proceedings.

E. An insured's or enrollee's genetic information is the property of the insured or enrollee. No person shall retain an insured's or enrollee's genetic information without first obtaining authorization from the insured, enrollee, or their representative, unless retention is:

(1) For the purposes of a criminal or death investigation or for use of in a criminal or juvenile proceeding.

(2) To determine paternity.

F.(1) Any person who through negligence collects, stores, or analyzes a DNA sample in violation of this Section, or discloses genetic information in violation of this Section, shall be liable to the individual for each such violation in an amount equal to:

(a) Any actual damages sustained as a result of the collection, storage, analysis, or disclosure, or fifty thousand dollars, whichever is greater.

(b) Treble damages, in any case where such a violation resulted in profit or monetary gain.

(c) The costs of the action together with reasonable attorney fees as determined by the court, in the case of a successful action to enforce any liability under this Section.

(2) Any person who:

(a) Through a request, the use of persuasion, under threat, or with a promise of reward, willfully induces another to collect, store, or analyze a DNA sample in violation of this Section; or

(b) Willfully collects, stores, or analyzes a DNA sample in violation of this Section, or willfully discloses genetic information in violation of this Section, shall be liable to the individual for each such violation in an amount equal to:

(i) Any actual damages sustained as a result of the collection, analysis, or disclosure, or one hundred thousand dollars, whichever is greater.

(ii) The costs of the action together with reasonable attorney fees as determined by the court, in the case of a successful action under this Section.

G. Notwithstanding any provision to the contrary, this Section does not apply to any actions of an insurer or third parties dealing with an insurer taken in the ordinary course of business in connection with the sale, issuance, or administration of a life, disability income, long-term care, or critical illness insurance policy. For the purposes of this Section, "critical illness" insurance policy shall mean health insurance providing a principle sum of benefit following diagnosis of specifically named perils.

Acts 1997, No. 1418, §1; Acts 2003, No. 129, §1, eff. May 28, 2003; Acts 2004, No. 325, §1, eff. June 18, 2004.

§214. REPEALED BY ACTS 1993, NO. 652, §2, EFF. JAN. 1, 1994.
§214.1. REPEALED BY ACTS 1997, No. 1138, §2, eff. July 14, 1997.
§214.2. Health insurance rejections, Louisiana Health Insurance Plan High Risk Pool

Any rejection for individual health and accident insurance shall contain information stating that health insurance may be available through the Louisiana Health Insurance Plan. Every rejection shall also include the address and telephone number at which information on the Louisiana Health Insurance Plan can be obtained. In no event shall the information required by this Section appear on the rejection in a smaller print than any other required provision of the rejection. The requirements of this Section may be satisfied by providing a separate document to the rejection containing the required information in the required print size. In no event shall this information guarantee placement in the fund of the Louisiana Health Insurance Plan.

Acts 1993, No. 378, §1.

§214.3. Required proof of loss forms

A. The commissioner of insurance in consultation with the secretary of the Department of Health and Hospitals shall prescribe the use of the National Uniform Bill-82 (UB-82) or its successor, and the current Health Care Financing Administration (HCFA) Form 1500 or its successor, as the uniform proof of loss forms. After July 1, 1994, no insurance company writing policies of health and accident insurance or any administrator of a health benefit plan may require proof of loss to be on any claim form but the UB-82, or its successor, or HCFA Form 1500, or its successor, whichever is appropriate for the services rendered.

B. The commissioner of insurance, as allowed by the Health Insurance Portability and Accountability Act of 1996, shall review the uniform proof of loss forms prescribed under Subsection A of this Section, seek comments and suggestions from insurers, providers, and consumer groups about proposed improvements to the form, and determine whether any revisions should be made to the state assignable fields of either form that would simplify or otherwise improve the form. If the commissioner determines that the state assignable portions of either form should be revised, he shall make a revision request to the State Uniform Bill Implementation Committee and if approved, prescribe the use of the revised form by all insurance companies writing policies of health and accident insurance in Louisiana. After six months from the date that the commissioner has prescribed the use of any revised form, no insurance company writing policies of health or accident insurance or any administrator of a health benefit plan may require proof of loss to be on any claim form but the revised form when that is the appropriate form for the services rendered.

C. Each health care provider or hospital shall supply the claim form described in Subsection A of this Section and an itemized statement of all charges after the initial filing of the claim rendered to any person who received services from such health care provider or hospital within ten days of receipt of written request from such person or his authorized representative.

Acts 1993, No. 388, §1; Acts 1997, No. 1138, §1, eff. July 14, 1997; Acts 2003, No. 1149, §1.

§215. Group, family group, blanket, and association health and accident insurance

A. Any insurer authorized to write health and accident insurance in this state shall have power to issue policies described in this Section.

(1) Group health and accident insurance is any policy of health and accident insurance, or similar coverage issued by a health maintenance organization, covering more than one person, except family group, and blanket policies hereinafter specifically provided for, which shall conform to the following requirements:

(a)(i) The policy shall be issued to an employer or association, or trustees of a fund established by an employer or association, who shall be deemed the policyholder, covering one or more employees of such employer or one or more employees of members of such association, for the benefit of persons other than the employer, or the association, its officers or trustees, upon some plan which will preclude individual selection.

(ii) The premium may be paid by the employer or association, by the employees or members, or by the two parties jointly. An insurer may but shall not be required to establish a percentage of eligible employees who are required to enroll and participate in a group health and accident policy if the entire premium is not paid by the employer or association.

(iii) If the policy is issued to any employer, any class or classes of employees eligible for coverage must be determined by conditions pertaining to their employment or age.

(iv) No such policy issued under individual certificates and considered as individual insurance coverage for purposes of this Part and Part VI-C of this Chapter may be issued to an association unless such association, having had an active existence for at least five years, has a constitution and bylaws and has been organized and is maintained in good faith for purposes other than those of obtaining insurance. No such policy, issued and considered as group health insurance, as defined under R.S. 22:250.1(2)(c), may be issued to an association unless it is a bona fide association as defined under R.S. 22:250.1(5)(b).

(v) The insurer shall issue to the employer or association for delivery to each employee or member insured under such group policy, an individual certificate containing a statement as to the insurance protection to which he is entitled and to whom payable.

(vi) The policy may be issued to an employer, association, or to the trustees of a fund established by two or more employers in the same industry or by one or more labor unions, or by one or more employers and one or more labor unions, or to a multiple employer trust established by an insurer on behalf of participating employers, provided all participating employers and employees have the same statutory protections that would apply if such policy was purchased by the employer directly from the insurer, which trustees shall be deemed the policyholder, to insure with or without any eligible family members including spouse, unmarried children under twenty-one years of age, and unmarried grandchildren who are in the legal custody of and residing with the grandparent under twenty-one years of age, employees of the employers or members of the association or of the unions for the benefit of persons other than the employers or the unions.

(b) The benefits payable under any policy or contract of group health and accident insurance shall be payable to the employee or members or to some beneficiary or beneficiaries designated by him, other than the employer, but if there is no designated beneficiary as to all or any part of the insurance at the death of the employee or member, then the amount of insurance payable for which there is no designated beneficiary shall be payable to the estate of the employee or member, except that the insurer may in such case, at its option, pay such insurance to any one or more of the following surviving relatives of the employee or member: wife, husband, mother, father, child, or children, brothers or sisters; and except that payment of benefits for expenses incurred on account of hospitalization or medical or surgical aid, may be made by the insurer to the hospital or other person or persons furnishing such aid. Payment so made shall discharge the insurer's obligations with respect to the amount of insurance so paid.

(c) REPEALED BY ACTS 2003, No. 129, §2, eff. May 28, 2003.

(d) Except as may otherwise be provided in the policy or contract of group health and accident insurance or by R.S. 22:228, the policyholder and the insurer may agree to modify, amend, or cancel the group policy, and such agreement shall be binding upon the employee or member insured under the group policy, provided that the modification, amendment, or cancellation shall be without prejudice to any claim for benefits accrued, or for expenses incurred for services rendered, prior to such modification, amendment, or cancellation. Benefits and expenses incurred shall be as defined and limited by the terms of the policy; however, upon cancellation by the insurer, the insurer shall only be liable for any claim for benefits accrued, or for expenses incurred for services rendered, subsequent to the cancellation date if the subsequent claim is for an illness or condition which was the basis of any claim prior to cancellation and for which the insurer had notice. Any cancellation pursuant to this Paragraph shall also comply with the provisions of R.S. 22:636(F).

(e) Except as may otherwise be provided in the policy or contract of group health and accident insurance, the insurer shall not be liable for benefits accrued, or for expenses incurred for services rendered, subsequent to the termination date where the policy of insurance terminates for failure of the group policyholder to pay premiums or where the employee's or member's coverage terminated for failure of the employee or member to maintain eligibility as provided in the policy or contract of group health and accident insurance.

(2)(a) Except as provided in Subparagraph (b) of this Paragraph, family group health and accident insurance or similar coverage issued by a health maintenance organization is an individual policy covering any one person, with or without any eligible members, including spouse and unmarried children under twenty-one years of age or, in the case of full-time students, unmarried children under the age of twenty-four, and unmarried grandchildren under twenty-one years of age in the legal custody of and residing with the grandparent or, in the case of full-time students, unmarried grandchildren under the age of twenty-four who are in the legal custody of and residing with the grandparent, except that the policy may provide for continuing coverage for any unmarried child or grandchild in the legal custody of and residing with the grandparent who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, who became so incapable prior to attainment of age twenty-one, and any other person dependent upon the policyholder, written under a master policy issued to the head of such family. The policy shall contain a provision that the policy, and the application of the head of the family if attached thereto, shall constitute the entire contract between the parties.

(b) Every family group health and accident insurance policy or health maintenance organization subscriber agreement which provides coverage, pursuant to Subparagraph (a) of this Paragraph, to a policyholder's unmarried children under the age of twenty-four who are full-time students or the policyholder's unmarried grandchildren in the legal custody of and residing with the policyholder who are full-time students under the age of twenty-four shall continue coverage under such policy if such child or grandchild develops a mental or nervous condition, problem, or disorder which, in the opinion of a qualified psychiatrist, subject, if deemed necessary by the insurer or health maintenance organization, to a second opinion, prevents the unmarried child or grandchild from attending school as a full-time student and from holding self-sustaining employment provided the child or grandchild is under the age of twenty-four.

(3) Blanket health and accident insurance is any policy covering special groups of persons as enumerated in one of the following Subparagraphs (a) through (g):

(a) Under a policy or contract issued to any common carrier, which shall be deemed the policyholder, covering a group defined as all persons who may become passengers on such common carrier.

(b) Under a policy issued to an employer, who shall be deemed the policyholder, covering any group of employees defined by reference to exceptional hazards incident to such employment.

(c) Under a policy issued to a college, school, or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or teachers.

(d) Under a policy issued in the name of any volunteer fire department, first aid, or other such volunteer group, which shall be deemed the policyholder, covering all of the members of such department or group.

(e) Under a policy or contract issued to a creditor who shall be deemed the policyholder to insure debtors of the creditor.

(f) Under a policy issued to any other substantially similar group which, in the discretion of the commissioner of insurance, may be subject to the issuance of a blanket health and accident policy.

(g) Under a policy or contract issued to the Department of Health and Hospitals, which shall be deemed the policyholder, covering a group defined as all persons who are eligible for medical assistance pursuant to a coverage program implemented pursuant to approval of the secretary of the United States Department of Health and Human Services using authority granted under Section 1115 of the Social Security Act.

(h) An individual application shall not be required from a person covered under such a blanket policy. The insurer shall furnish to the policyholder for delivery to the insured a certificate of insurance which shall disclose the benefits, limitations, exclusions, and reductions contained in the policy and the provisions relating to notice of claim, proof of loss, time of payment of claim, and any other relevant information, including the name and address of the insurer. All benefits under any such blanket policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, if the policy permits the designation of named beneficiaries, or to his estate, except that if the person insured be a minor such benefits may be made payable to his parent, guardian, or other person actually supporting him.

(4) REPEALED BY ACTS 2003, No. 129, §2, eff. May 28, 2003.

B. The term "employees" as used in this Section shall be deemed to include, for the purposes of insurance hereunder, as employees of a single employer, the officers, managers, and employees of the employer and of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, and employees of individuals and firms of which the business is controlled by the insured employer through stock ownership, contract or otherwise. The term "employer" as used herein may be deemed to include any governmental corporation, unit, agency or department thereof, or the proper officers, as such, of any unincorporated governmental organization.

C. Insurers issuing policies under this Section shall be subject to all the other applicable provisions of this Part and Part VI-C. In addition, policies issued under this Section shall also contain a provision that to the group or class thereof originally insured shall be added:

(1) All new persons becoming eligible for and applying for insurance in such group or class, including new members of a family group; and

(2) Any persons required to be provided coverage under federal law who apply for insurance in such group or class.

D. Any policy issued under this Section may provide for the readjustment of the rate of premium based on the experience thereunder at the end of the first year or of any subsequent year of insurance thereunder, and such readjustment may be made retroactive only for such policy year. Any refund under any plan for readjustment of the rate of premium based on the experience under group policies heretofore or hereafter issued, and any dividend paid under such policies may be issued to reduce the employer's share of the cost of the coverage, except that if the aggregate refunds or dividends under such group policy and any other group policy or contract issued to the policyholder exceed the aggregate contributions of the employer toward the cost of the coverages, such excess shall be applied by the policyholder for the sole benefit of insured employees.

E. Any group, family group, blanket, or association health and accident insurer, including a group health plan as defined by Section 607(1) of the Employee Retirement Income Security Act of 1974, self-insurance plan, health maintenance organization, nonprofit hospital or medical service organization, or the Office of Group Benefits, shall be prohibited from any consideration of the availability or eligibility for medical assistance in this or any other state, as mandated under federal law, as a requirement of eligibility for coverage or payment under its policy, plan, certificate, or agreement for its policyholders, enrollees, members, certificate holders, or their dependents.

Acts 1958, No. 125. Amended by Acts 1966, No. 172, §1; Acts 1972, No. 138, §1; Acts 1972, No. 415, §1; Acts 1980, No. 701, §1; Acts 1985, No. 249, §1; Acts 1989, No. 269, §1; Acts 1991, No. 777, §1, eff. Sept. 30, 1991; Acts 1992, No. 637, §1, eff. July 2, 1992; Acts 1993, No. 57, §1; Acts 1993, No. 296, §1; Acts 1993, No. 652, §1, eff. Jan. 1, 1994; Acts 1993, No. 663, §1, eff. June 16, 1993; Acts 1995, No. 593, §2; Acts 1995, No. 717, §1; Acts 1997, No. 1138, §1, eff. July 14, 1997; Acts 1997, No. 1175, §1; Acts 1999, No. 474, 30, §1; Acts 2001, No. 1178, §2, eff. June 29, 2001; Acts 2003, No. 129, §§1 & 2, eff. May 28, 2003; Acts 2004, No. 325, §1, eff. June 18, 2004; Acts 2004, No. 751, §1.

§215.1. Group, family group, blanket and association health and accident insurance

A. Any policy issued under this Section, which in addition to covering the insured also covers members of the insured's immediate family, shall provide coverage for illnesses and injuries of unmarried dependent children of the insured and unmarried grandchildren in the legal custody of the grandparent from the date of birth to the attainment of the limiting age. Such coverage so provided shall include coverage for illness, injury, congenital defects, and premature birth, but need not include routine well baby care.

B.(1) All policies issued more than ninety days following September 1, 1979, which in addition to covering the insured also cover members of the insured's immediate family, shall offer coverage for the transportation by professional ambulance services, including air or surface transport, of all the newly born to the nearest available hospital or neonatal special care unit for treatment of illnesses, injuries, congenital defects, and complications of premature birth but the coverage need not include transportation services for the purpose of obtaining routine well baby care.

(2) Such policies shall also provide coverage for transportation by professional ambulance services of the temporarily medically disabled mother of the ill newly born when accompanying the ill newly born to the nearest available hospital or neonatal special care unit. The mother's need for professional ambulance service must be certified by her attending physician.

C. For the purpose of this Section the following definitions shall apply:

(1) "Newly born" means infants from the time of birth until age one month or until such time as the infant is well enough to be discharged from a hospital or neonatal special care unit to his home, whichever period is longer.

(2) "Temporarily medically disabled mother" means a woman who has recently given birth and whose physician has advised that normal travel would be hazardous to her health.

D. The provisions of this Section shall not apply to individually underwritten, guaranteed renewable or renewable limited benefit supplemental health insurance policies authorized to be issued in this state.

Added by Acts 1973, No. 98, §§1, 2. Amended by Acts 1979, No. 470, §1; Acts 1992, No. 637, §1, eff. July 2, 1992; Acts 1997, No. 1268, §1; Acts 2003, No. 129, §3, eff. May 28, 2003.

§215.2. Mandatory coverage and continued coverage of physically or mentally handicapped children of insured

A. Any hospital or medical expense insurance policy delivered or issued for delivery in this state more than ninety days after July 2, 1973, which provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (1) incapable of self sustaining employment, and (2) chiefly dependent upon the policyholder, employee or member for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer by the employee or member within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

B. Any hospital or medical expense insurance policy described in Subsection A and delivered in this state on or prior to ninety days after July 2, 1973, shall be endorsed to include coverage for such child who had attained the limiting age on or prior to ninety days after July 2, 1973 while such child is or continues to be both (1) incapable of self sustaining employment by reason of mental or physical handicap, and (2) chiefly dependent upon the policyholder, employee or member for support and maintenance, provided such incapacity existed prior to the attainment of the limiting age for dependent children under such group policy and proof of such incapacity and dependency is furnished to the insurer by the employee or member on or before January 1, 1975, and subsequently as may be required by the insurer, but not more frequently than annually.

Added by Acts 1973, No. 99, §§1, 2. Amended by Acts 1974, No. 534, §1.

§215.3. Coverage of vocational-technical students

Children who attend vocational, technical, vocational-technical or trade schools or institutes in Louisiana on a full-time basis shall be considered as full-time students for purposes of coverage by family group health and accident insurance policies issued in this state.

The provisions of this section shall apply to all policies issued more than ninety days following July 31, 1974. Any insurer who, on July 31, 1974, has health and accident insurance policies in force shall have until July 31, 1975 to convert such existing policies to conform to the provisions of this section.

Added by Acts 1974, No. 148, §1.

§215.4. Coverage of unmarried students

A.(1) Except as provided in Paragraph (2) of this Subsection, students who are unmarried children who have not yet attained the age of twenty-four and who are enrolled as full-time students at an accredited college or university, or at a vocational, technical, vocational-technical or trade school or institute, or secondary school, and who are dependent upon the primary insured under any group health and accident or association health and accident insurance policy or health maintenance organization subscriber agreement issued in this state for their support, shall be considered as dependents under the provisions of said policy.

(2) Every unmarried child under the age of twenty-four who is enrolled as a full-time student at an accredited college or university, or a vocational, technical, vocational-technical, or trade school or institute, or secondary school and who is dependent for their support on the primary insured under any group health and accident or association health and accident insurance policy issued in this state shall continue to be considered a dependent under the provisions of such policy if the unmarried child develops a mental or nervous condition, problem, or disorder which renders the unmarried child, in the opinion of a qualified psychiatrist, subject, if deemed necessary by the insurer or health maintenance organization, to a second opinion, unable to attend school as a full-time student and from holding self-sustaining employment until the student reaches the age of twenty-four.

B. The provisions of this Section shall apply to all policies issued or renewed or issued for delivery in this state after September 1, 1997. Any insurer who, on September 1, 1997, has health and accident insurance policies or health maintenance organization subscriber agreements in force in this state shall have until September 1, 1998, to convert such existing policies to conform to the provisions of this Section.

Added by Acts 1974, No. 505, §1; Acts 1997, No. 1175, §1; Acts 2003, No. 129, §1, eff. May 28, 2003.

§215.5. Group, blanket, and association health insurance, treatment for alcoholism and drug abuse

A. Any group, blanket, or association health insurance policy issued under R.S. 22:215 shall include as an option to be exercised by the policyholder, as defined therein, covered benefits for the treatment of alcoholism and for the treatment of drug abuse, rendered or prescribed by a physician licensed in this state, received in any licensed hospital or in any other public or private facility, or portion thereof duly authorized by the appropriate state authority to provide alcoholism or drug abuse treatment and rehabilitation services, including freestanding, nonhospital chemical dependency units.

B. Any insurer who, on October 1, 1982, has group, blanket, or association health insurance policies in force shall convert such existing policies to conform to the provisions of this Section on or before the renewal dates thereof.

Added by Acts 1974, No. 252, §1. Amended by Acts 1979, No. 58, §1; Acts 1982, No. 849, §1; Acts 2003, No. 129, §1, eff. May 28, 2003.

§215.6. Health benefit plans; replacement; continuance of benefits

A. This Section shall apply to any health benefit plan that provides coverage to two or more employees of an employer in this state if any of the following conditions is satisfied:

(1) Any portion of the premium or benefits is paid by or on behalf of the employer.

(2) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the employer for any portion of the premium.

(3) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Sections 162, 125, or 106 of the United States Internal Revenue Code.

B. This Section shall not apply to a health benefit plan which was issued in good faith with no knowledge or intent that the plan will, at the time of issuance or thereafter, satisfy one or more of the conditions set forth in Subsection A of this Section, and the insurer has certified to the Department of Insurance that the policy form:

(1) Is not designed to be an employer-provided insurance.

(2) Is not intended to be an employer-provided insurance.

(3) Will not be advertised or marketed as employer-provided insurance.

(4) Will not be issued if the insurer knows that the policy will meet one or more of the conditions set forth in Subsection A of this Section.

C. "Health benefit plan" means any hospital or medical policy or group certificate delivered or issued for delivery in this state by an insurer; a nonprofit hospital or medical service organization; a domestic nonprofit mutual association which is engaged exclusively in the furnishing of hospital service, medical, or surgical benefits; a health maintenance organization; or a self-insured plan that provides, on an expense-incurred basis, hospital, surgical, or major medical expense insurance, or any combination of these except specified disease, hospital indemnity or other limited, supplemental benefit insurance policies.

D. Under the provisions of this Section, the replacement of insurance shall also refer to any insurance issued by a second insurer within sixty days of the termination of coverage by the prior insurer.

E. Whenever a contract of one carrier replaces a health benefit plan of similar benefits of another carrier:

(1) The prior carrier shall remain liable only to the extent of its accrued liabilities. The position of the prior carrier shall be the same whether the group policyholder or other entity secures replacement coverage from a new carrier, or a self-insurer, or foregoes the provision of coverage.

(2) Each person who was validly covered or eligible to be covered under the prior health plan, shall be offered coverage by the succeeding carrier's plan of benefits. No previously covered person shall be considered ineligible for coverage.

(3) The succeeding carrier, in determining whether a preexisting condition provision applies to an eligible employee or dependent, shall credit the time the person was covered under the prior plan if the previous coverage was continuous to a date not more than sixty-three days prior to the effective date of the new coverage. The succeeding carrier shall credit coverage in accordance with Part VI-C of this Chapter, and reasonable regulations issued by the commissioner of insurance under the Administrative Procedure Act for the enforcement thereof.

(4) The succeeding carrier, in applying any deductibles or waiting periods in its plan, shall give credit for satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provisions of the prior carrier's plan during the ninety days preceding the effective date of the succeeding carrier's plan, but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to similar deductible provisions.

(5) Whenever a determination of the prior carrier's benefits is required by the succeeding carrier, at the succeeding carrier's request, the prior carrier shall furnish a statement of the benefits available, pertinent information, sufficient to permit verification of the benefit determination, or the determination itself by the succeeding carrier. For purposes of this Paragraph, benefits of the prior plan shall be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination will be made as if coverage was not replaced by the succeeding carrier.

Added by Acts 1977, No. 332, §1. Acts 1992, No. 342, §1; Acts 1992, No. 534, §1; Acts 1993, No. 473, §1; Acts 1997, No. 1138, §1, eff. July 14, 1997.

§215.7. Group, blanket, and association health and accident insurance; continuation of coverage

A. Each group, blanket, or association insurance policy containing provisions for payment by the insurer of benefits for expenses incurred for hospital, nursing, medical, or surgical services, issued or renewed in this state on or after September 9, 1983, shall include within its provisions the following:

(1) An option for all surviving spouses, that are fifty years of age or greater, of deceased employees covered by the group plan by virtue of their family relationship to a group member to continue as a member of the group plan when their eligibility for group coverage ceases due to death of the employee-member.

(2) The continuation option provided for above shall not be conditioned upon any physical examination.

(3) The continuation option shall entitle the surviving spouse to coverage identical in scope to that provided for under the group plan.

(4) The policyholder shall be responsible for billing and collection of the premium; however, the premium amount shall not exceed the premium assessed for each group member under the group insurance policy. The premium shall be based upon the community costs of the pool of members of the group insurance policy, family members, or dependents covered under the group policy.

(5) The surviving spouse shall have ninety days after the date of death to notify the insurer that the continuation option will be exercised. Coverage under the group insurance plan shall not be terminated during the ninety day notification period. No probationary or waiting period shall be required.

(6) If the continuation option is exercised, coverage of the surviving spouse under the group plan shall continue without interruption and may not be terminated, unless one of the following occurs:

(a) The insured fails to make timely payment of the required premium amount.

(b) The insured becomes eligible for Medicare benefits.

(c) The insured becomes eligible to participate in another group health and accident insurance plan.

(d) The insured remarries.

B. If the insurer has been furnished with the home address of the surviving spouse and has been notified of the death of the employee by the policy owner, the insurer shall notify the surviving spouse of the right to the continuation option.

C. This Section shall not be construed to interfere with or diminish any protection already provided pursuant to collective bargaining agreements and employer-sponsored plans that are more favorable to the surviving spouses benefited thereby than the protection offered by this Section.

Added by Acts 1983, No. 513, §1; Acts 2003, No. 129, §1, eff. May 28, 2003.

§215.8. Group, family group, blanket, and association health and accident insurance; cleft lip and cleft palate coverage; mandatory coverage

A. Any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan, and a self-insurance plan that provides medical and surgical benefits which is delivered, issued for delivery or renewed in this state on or after January 1, 1998, shall include coverage for the treatment and correction of cleft lip and cleft palate. Such coverage shall also include benefits for secondary conditions and treatment attributable to that primary medical condition. Benefits shall include but not be limited to the following:

(1) Oral and facial surgery, surgical management, and follow-up care.

(2) Prosthetic treatment such as obturators, speech appliances, and feeding appliances.

(3) Orthodontic treatment and management.

(4) Preventive and restorative dentistry to insure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.

(5) Speech-language evaluation and therapy.

(6) Audiological assessments and amplification devices.

(7) Otolaryngology treatment and management.

(8) Psychological assessment and counseling.

(9) Genetic assessment and counseling for patient and parents.

B. The provisions of this Section shall not apply to individually underwritten guaranteed renewable or renewable limited benefit supplemental health insurance policies, limited benefit policies, or specified disease policies authorized to be issued in this state.

Acts 1989, No. 409, §1; Acts 1997, No. 1355, §1; Acts 2003, No. 129, §3, eff. May 28, 2003.

§215.9. Group, family group, blanket, and association health and accident insurance; notice required for certain premium increase, cancellation, or nonrenewal

A.(1) Notwithstanding the provisions of R.S. 22:636(A) through (D), every insurer, including any trust subject to the provisions of R.S. 22:2041 et seq., whether domestic or foreign, issuing a policy of group, family group, blanket, or association health and accident insurance under the provisions of this Part to any group composed of one or more members shall notify the policyholder in writing at least forty-five days before any increase of twenty percent or more in the policy rates or at least sixty days before any cancellation or nonrenewal of such policy. Such cancellation or nonrenewal shall comply with the provisions of R.S. 22:636(F).

(2) The notice required by Paragraph (1) of this Subsection may be waived for a policy of group, family group, blanket, or association health and accident insurance which covers one hundred or more persons, provided a provision for such waiver is made part of the policy agreed upon by the insurer and the policyholder.

B. Nothing in this Section shall be construed to grant to the insurer any additional authorization in relation to cancellation, nonrenewal, or other termination of policies and all provisions of this Part which regulate such events shall apply. No policy shall be cancelled, nonrenewed, or otherwise terminated because the insurer failed to meet the notice provisions of this Section.

C. The notice provisions of this Section shall not apply to cancellations due to nonpayment o f premiums.

Acts 1990, No. 538, §1; Acts 1991, No. 933, §1; Acts 1993, No. 57, §1; Acts 2003, No. 129, §1, eff. May 28, 2003.

§215.10. Hearing-impaired interpreter expenses

A. Any hospital or medical expense insurance policy delivered or issued for delivery in this state on or after December 1, 1991, shall contain a provision or endorsement requiring payment for expenses incurred by the insured for services performed by a qualified interpreter/transliterator, other than a family member of the insured, when such services are used by the insured in connection with medical treatment or diagnostic consultations performed by a physician, dentist, chiropractor, or podiatrist, provided such medical treatment or consultation is covered under said insurance policy and provided the services are required because of a hearing impairment of the insured or a failure of the insured to understand or otherwise communicate in spoken language.

B. The provisions of this Section shall not apply to individually underwritten limited benefit and supplemental health insurance policies.

Acts 1991, No. 609, §1; Acts 1995, No. 593, §1.

§215.11. Early screening and detection requirements; examination; coverage

A.(1) Any health coverage plan which is delivered or issued for delivery in this state shall include benefits payable for an annual Pap test and minimum mammography examination as provided in this Subsection.

(2) In this Subsection, "minimum mammography examination" means mammographic examinations performed no less frequently than the following schedule provides:

(a) One baseline mammogram for any woman who is thirty-five through thirty-nine years of age.

(b) One mammogram every twenty-four months for any woman who is forty through forty-nine years of age, or more frequently if recommended by her physician.

(c) One mammogram every twelve months for any woman who is fifty years of age or older.

(3) The annual Pap test for cervical cancer and the minimum mammography examination shall be covered when rendered or prescribed by a physician or other appropriate health care provider licensed in this state and received in any licensed hospital or in any other licensed public or private facility, or portion thereof, including but not limited to clinics and mobile screening units.

(4) This Subsection shall apply to any new policy, contract, program, or health coverage plan issued on or after January l, 1992. Any policy, contract, or health coverage plan in effect prior to January l, 1992, shall convert to conform to the provisions of this Subsection on or before the renewal date thereof but in no event later than January 1, 1993.

(5) No health coverage plan which is delivered or issued for delivery in this state shall prevent any insured, beneficiary, enrollee, or subscriber from having direct access, without any requirement for specialty referral, to the minimum mammography examination required to be covered by this Subsection.

B.(1) Any health coverage plan which is delivered or issued for delivery in the state shall provide coverage for detection of prostate cancer, including digital rectal examination and prostate-specific antigen testing for men over the age of fifty years and as medically necessary and appropriate for men over the age of forty years.

(2) "Routine prostate preventative care" as used in this Subsection, shall mean a minimum of one routine annual visit, provided that a second visit shall be permitted based upon medical need and follow-up treatment within sixty days after either visit if related to a condition diagnosed or treated during the visits.

(3) This Subsection shall apply to any new policy, contract, program, or health coverage plan issued on and after January 1, 1998. Any policy, contract, or health coverage plan in effect prior to January 1, 1998, shall convert to conform to the provisions of this Subsection on or before the renewal date, but no later than January 1, 1998.

C. As used in this Section, "health coverage plan" shall mean any hospital, health, or medical expense insurance policy, hospital or medical service contract, health and accident insurance policy, or any other contract of this type, including a group insurance plan, or any policy of family group, blanket, or association health and accident insurance, a self-insurance plan, an employee welfare benefit plan, and a health maintenance organization subscriber agreement. Unless otherwise specifically provided in the policy of insurance, nothing in this Section shall apply to high deductible coverage as defined under the Internal Revenue Code of 1986, or similar coverage with a greater deductible amount, limited benefit and supplemental health insurance policies including individually underwritten high deductible coverage as defined under the Internal Revenue Code of 1986, or similar coverage with a greater deductible amount limited benefit and supplemental health insurance policies.

D. For the purposes of this Section, effective July 1, 1998, a health coverage plan shall include the Office of Group Benefits programs.

E. Any coverage required under the provisions of this Section shall not be subject to any policy or health coverage plan deductible amount.

F. Any provision in a health insurance policy, benefit program, or health coverage plan under this Section which is delivered, renewed, issued for delivery, or otherwise contracted for in the state which is contrary to this Section shall, to the extent of the conflict, be void.

G. The provisions of this Section shall not apply to individually underwritten, guaranteed renewable, or renewable limited benefit supplemental health insurance policies authorized to be issued in this state.

Acts 1991, No. 387, §1; Acts 1991, No. 994, §1; Acts 1992, No. 462, §1; Acts 1995, No. 593, §1; Acts 1997, No. 1439, §1, eff. July 15, 1997; Acts 2001, No. 1116, §1; Acts 2001, No. 1178, §2, eff. June 29, 2001; Acts 2003, No. 129, §1, eff. May 28, 2003.

§215.12. Requirement for coverage of colorectal cancer screening

A. Any health coverage plan specified in Subsection C of this Section which is issued for delivery, delivered, renewed, or otherwise contracted for in this state on or after January 1, 2006, shall provide coverage for routine colorectal cancer screening.

B. As used in this Section, "routine colorectal cancer screening" shall mean a fecal occult blood test, flexible sigmoidoscopy, or colonoscopy provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations. "Routine colorectal cancer screening" shall not mean services otherwise excluded from coverage because they are deemed by a health coverage plan to be experimental or investigational.

C. As used in this Section, "health coverage plan" shall mean any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan, a self-insurance plan, and the Office of Group Benefits programs.

D. The provisions of this Section shall not apply to individually underwritten, guaranteed renewable limited benefit health insurance policies.

Added by Acts 2005, No. 505, §1, eff. July 12, 2005.

§215.13. Group health insurance continuation

A. As used in this Section the following terms shall have the following meanings:

(1) "Group policy" means a group accident and health insurance policy or group certificate delivered or issued for delivery in this state by an insurer, a nonprofit hospital or medical service organization, a domestic nonprofit mutual association which is engaged exclusively in the furnishing of hospital services, medical or surgical benefits, a health maintenance organization, or a self-insured plan.

(2) "Medicare" means Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded.

(3) "Premium" means any premium or other consideration payable for coverage under a group or individual policy.

B. A group policy delivered or issued for delivery in this state which insures employees or members, and their eligible dependents, if they have elected to include them, for hospital, surgical or major medical insurance on an expense incurred or service basis, other than for specific diseases or for accidental injuries only, shall provide that employees or members whose insurance for these types of coverage under the group policy would otherwise terminate because of termination of active employment or membership, or termination of membership in the eligible class or classes under the policy shall be entitled to continue their hospital, surgical, and medical insurance under that group policy, for themselves and their eligible dependents with respect to whom they were insured on the date of termination, subject to all of the group policy's terms and conditions applicable to those forms of insurance and to the conditions specified in this Section. The terms and conditions set forth in this Section are intended as minimum requirements and shall not be construed to impose additional or different requirements upon those group hospital, surgical, or major medical plans already in force, or hereafter placed into effect, that provide continuation benefits equal to or better than those required in this Section.

C. Continuation shall only be available to an employee or member who has been continuously insured under the group policy, or for similar benefits under any other group policy that it replaced, during the period of three consecutive months immediately prior to the date of termination. The continued policy must cover all dependents covered under the group policy.

D. Continuation shall not be available for any person who is or could be covered by any other arrangement of hospital, surgical, or medical coverage for individuals in a group, whether insured or uninsured, within thirty-one days immediately following the date of termination, or whose insurance terminated because of fraud or because he failed to pay any required contribution for the insurance, or who is eligible for continuation under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA).

E. Continuation may not include dental, vision care, or any other benefits provided under the group policy in addition to its hospital, surgical, or major medical benefits.

F. An employee or member electing continuation shall pay to the group policyholder or his employer, in advance, the amount of contribution required by the policyholder or employer, but not more than the full group rate for the insurance applicable to the employee or member under the group policy on the due date of each payment. The employee or member shall not be required to pay the amount of the contribution less often than monthly. In order to be eligible for continuation of coverage, the employee or member shall make a written election of continuation, on a form furnished by the group policyholder, and pay the first contribution, in advance, to the policyholder or employer on or before the date on which the employee's or member's insurance would otherwise terminate. Such form shall be as prescribed in this Section.

G. Continuation of insurance under the group policy for any person shall terminate on the earliest of the following dates:

(1) The date twelve months after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or membership.

(2) The date ending the period for which the employee or member last makes his required contribution, if he discontinues his contributions.

(3) The date the employee or member becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured.

(4) The date on which the group policy is terminated or, in the case of a multiple employer plan, the date his employer terminates participation under the group master policy. When this occurs the employee or member shall have a conversion privilege if the date of termination precedes that on which his actual continuation of insurance under that policy would have terminated. The insurer that insured the group prior to the date of termination shall make a converted policy available to the employee or member.

(5) The date on which an enrolled member of a health maintenance organization legally resides outside the service area of the organization.

H. A notification of the continuation privilege shall be included in each individual certification of coverage.

Acts 1992, No. 343, §1; Acts 1993, No. 659, §1.

§215.14. Immunizations; coverage

A. Any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan and a self-insurance plan, which is delivered or issued for delivery in this state on or after January 1, 1993, shall include benefits payable for immunizations for dependent children from birth to age six. These benefits shall be payable under the same circumstances and conditions as benefits are paid under those policies, contracts, benefit plans, agreements, or programs for all other diagnoses, treatments, illnesses, or accidents.

B. The immunizations covered shall include the complete basic immunization series for children up to age six as defined by the state health officer and required for school entry.

C. This Section shall apply to any new policy, contract, program, or plan issued on or after January 1, 1993. Any policy, contract, or plan in effect prior to January 1, 1993, shall convert to conform to the provisions of this Section on or before the renewal date thereof but in no event later than January 1, 1994. Any policy affected by this Section shall only be required to provide coverage for children born after August 21, 1992.

D. The provisions of this Section shall not apply to individually underwritten limited benefit and supplemental health insurance policies.

E. Any coverage required under the provisions of this Section shall not be subject to any policy or health coverage plan deductible amount. The provision in this Subsection shall apply to any new policy, contract, program, or plan issued on or after January 1, 2005. Any policy, contract, or plan in effect prior to January 1, 2005, shall convert to conform to the provision of this Subsection on or before the renewal date thereof but in no event later than January 1, 2006.

Acts 1992, No. 756, §1; Acts 1993, No. 185, §1; Acts 1995, No. 593, §1; Acts 2001, No. 1178, §2, eff. June 29, 2001; Acts 2004, No. 431, §1.

§215.15. Attention deficit/hyperactivity disorder; coverage; diagnosis

A. Any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan, or any policy of group, family group, blanket, or association health and accident insurance, and a self-insurance plan, which is delivered or issued for delivery in this state on or after January 1, 1994, shall include benefits payable for diagnosis and treatment of attention deficit/hyperactivity disorder as provided in this Section. These benefits shall be payable under the same circumstances and conditions as benefits are paid under those policies, contracts, benefit plans, agreements, or programs for all other diagnoses, illnesses, or accidents.

B. The diagnosis and treatment for attention deficit/hyperactivity disorder shall be covered when rendered or prescribed by a physician or other appropriate health care provider licensed in this state and received in any physician's or other appropriate health care provider's office, any licensed hospital, or in any other licensed public or private facility, or portion thereof, including but not limited to clinics and mobil screening units. However, benefits for attention deficit/hyperactivity disorder provided for an initial diagnosis shall not exceed six hundred dollars. Services rendered on an out-patient basis shall not exceed fifty dollars per visit with a physician or other appropriate health care provider and total benefits shall be limited to ten thousand dollars during a person's lifetime, and shall not exceed twenty-five hundred dollars in any given year. The limitation on benefits payable for attention deficit/hyperactivity disorder shall be minimum levels of coverage and nothing in this Section shall prohibit insurers from offering benefits in excess of the coverage provided for in this Subsection.

C. This Section shall apply to any new policy, contract, program, or plan issued on or after January 1, 1994. Any policy, contract, or plan in effect prior to January 1, 1994, shall convert to conform to the provisions of this Section on or before the renewal date thereof but in no event later than January 1, 1995.

D. The provisions of this Section shall not apply to individually underwritten limited benefit and supplemental health insurance policies.

Acts 1993, No. 376, §1; Acts 1995, No. 593, §1; Acts 2003, No. 129, §1, eff. May 28, 2003.

§215.16. Osteoporosis; bone mass measurement; mandatory coverage

A. Any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan, and a self-insurance plan that provides medical and surgical benefits for accident and health services, which is delivered or issued for delivery in this state on or after January 1, 2000, shall include coverage for a qualified individual for scientifically proven bone mass measurement for the diagnosis and treatment of osteoporosis.

B. As used in this Section, the following definitions shall apply:

(1) "Bone mass measurement" means a radiologic or radioisotopic procedure or other scientifically proven technologies performed on an individual for the purpose of identifying bone mass or detecting bone loss.

(2) "Qualified individual" means:

(a) An estrogen-deficient woman at clinical risk of osteoporosis who is considering treatment.

(b) An individual receiving long-term steroid therapy.

(c) An individual being monitored to assess the response to or efficacy of approved osteoporosis drug therapies.

C. Nothing in this Section shall apply to individually underwritten limited benefit health insurance policies.

Acts 1999, No. 64, §1.

§215.17. Obstetrician or gynecological examination; coverage

A.(1) Every hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan, or any policy of group, family group, blanket, or association health and accident insurance, a self-insurance plan, health maintenance organization, and preferred provider organization, which is delivered or issued for delivery in this state shall not prevent any individual who is an insured, enrollee, or beneficiary of any such policy or benefit plan from receiving direct access to an obstetrician or gynecologist or in-network obstetrician or gynecologist for routine gynecological care. For those enrollees in a plan that has made agreements with providers for the provision of health care or related services, the provisions of this Subsection may limit direct access to any in-network obstetrician or gynecologist for routine gynecological care.

(2) Routine gynecological care as used in this Section shall mean a minimum of two routine annual visits, provided that the second visit shall be permitted based upon medical need only, and follow-up treatment within sixty days following either visit if related to a condition diagnosed or treated during the visits, and any care related to a pregnancy. Nothing in this Section shall prevent a policy, program, or plan from requiring that an obstetrician-gynecologist treating a covered patient coordinate that care with the patient's primary care physician, if applicable.

B. Any provision in a health insurance policy or benefit program which is delivered, renewed, issued for delivery, or otherwise contracted for in this state which is contrary to this Section shall, to the extent of such conflict, be void.

Acts 1995, No. 637, §1; Acts 2003, No. 129, §1, eff. May 28, 2003.

§215.18. Requirements of provider contracts; communications

A. As used in this Section, the following definitions shall apply:

(1) "Enrollee", "prospective enrollee", or "patient" means an individual, his spouse, and any dependent, if any, who is enrolled in a health maintenance organization or is a member or is applying to become a member of a health care benefit policy, plan, or package, either furnished to him through his employment as part of his compensation or entitlement furnished by a publicly funded program or purchased through his own financial resources.

(2) "Health care services" means any services rendered by providers which include, but are not limited to medical and surgical care; social work, psychological, optometric, optic, chiropractic, podiatric, nursing, and pharmaceutical services; health education, rehabilitative, and home health services; physical therapy; inpatient and outpatient hospital services; dietary and nutritional services; laboratory and ambulance services; and any other services for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability. Health care services also means dental care, limited to oral and maxillofacial surgery as performed by board-certified oral and maxillofacial surgeons and also include an annual PAP test for cervical cancer and minimum mammography examination as defined in R.S. 22:215.11.

(3) "Managed care organization" means a licensed insurance company, hospital or medical benefit plan or program, health maintenance organization, integrated health care delivery system, an employer or employee organization, or a managed care contractor which operates a managed care plan. A managed care organization may include but is not limited to a preferred provider organization, health maintenance organization, exclusive provider organization, independent practice association, clinic without walls, management services organization, managed care services organization, physician hospital organization, and hospital physician organization.

(4) "Managed care plan" means a plan operated by a managed care entity which provides for the financing and delivery of health care and treatment services to individuals enrolled in such plan through its own employed health care providers or contracting with selected specific providers that conform to explicit selection, standards, or both. A managed care plan also customarily has a formal organizational structure for continual quality assurance, a certified utilization review program, dispute resolution, and financial incentives for individual enrollees to use the plan's participating providers and procedures.

(5) "Participating provider", "provider", or "health care provider" means a state-licensed, certified, or state-registered provider of health care services, treatment, or supplies, including but not limited to those entities defined in R.S. 40:1299.41(A)(1), that have entered into a contract or agreement with a managed care entity to provide such services, treatment, or supplies to an individual enrollee or a patient.

(6) "Rural hospital" means either:

(a) A hospital with sixty or fewer beds located in either:

(i) A parish with a population of less than fifty thousand according to the most recent federal decennial census.

(ii) A municipality with a population of less than twenty thousand according to most recent federal decennial census.

(b) A hospital classified as a sole community hospital pursuant to 42 CFR 412.92.

(7) "Subscriber" means the person who is responsible for payment to a managed care organization or managed care entity or whose employment or other status, except for family dependence, is the basis for eligibility for enrollment in the managed care organization or managed care entity.

B. In a contract with a health care provider, a managed care organization shall not include provisions that interfere with the ability of a health care provider to communicate with a patient regarding his or her health care, including but not limited to communications regarding treatment options and medical alternatives, or other coverage arrangements. Notwithstanding the provisions of this Section, a managed care organization may include a contract provision that provides that a health care provider shall not solicit for alternative coverage arrangements for the primary purpose of securing financial gain.

C. No managed care organization shall refuse to contract, renew, cancel, restrict, or otherwise terminate a contract with a health care provider solely on the basis of a medical communication. No managed care organization shall refuse to refer patients to or allow others to refer patients to the health care provider, refuse to compensate the health care provider for covered services, or take other retaliatory action against the health care provider. As used in this Subsection "medical communication" shall mean information regarding the mental or physical health care needs or the treatment of a patient.

D. No communication regarding treatment options shall be represented or construed to expand or revise the scope of benefits or covered services under a managed care plan or insurance contract.

E. No managed care organization or managed care entity shall by contract, written policy, or written procedure prohibit or restrict any provider from filing a complaint, making a report, or commenting to an appropriate governmental body regarding the policies or practices of such managed care organization or managed care entity which may negatively impact upon the quality of, or access to, patient care.

F. No managed care organization or managed care entity shall by contract, written policy, or written procedure prohibit or restrict any health care provider from advocating to the managed care organization or managed care entity on behalf of the enrollee or subscriber for approval or coverage of a particular course of treatment or for the provision of health care services.

G. No contract or agreement between a managed care organization or managed care entity and a health care provider shall contain any clause purporting to transfer to the health care provider by indemnification or otherwise any liability relating to activities, actions, or omissions of the managed care organization or managed care entity.

H. Notwithstanding any other provision of law to the contrary, no managed care organization shall limit the right of a rural hospital to receive payment for covered health care services as long as a claim for payment of such services is submitted within one year after the date on which the rural hospital provided the services.

I. Any contract provision, written policy, or written procedure in violation of this Section shall be deemed to be unenforceable and null and void.

Acts 1997, No. 1232, §1; Acts 2001, No. 1198, §1, eff. June 29, 2001.

§215.19. Health and accident policy provisions; provider contracts; prohibited incentives

A. No hospital or medical service contract, health and accident policy, or any other insurance contract of this type shall include provisions which include an incentive or specific payment made directly, in any form, to a health care provider or health care provider group as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services provided with respect to a specific insured or groups of insureds with similar medical conditions.

B. Nothing in this Section shall be construed to prohibit contracts that contain incentive plans that involve general payments, such as capitation payments, or shared-risk arrangements that are not tied to specific medical decisions involving specific insured or groups of insureds with similar medical conditions. The payments rendered or to be rendered to physicians, physician groups, or other licensed health care providers under these arrangements shall be deemed confidential information.

Acts 1997, No. 897, §1.

§215.20. Coverage for use of drugs in treatment of cancer

A. As used in this Section, the following terms shall have the following meanings:

(1) "Medical literature" means scientific studies published in a journal specified by the United States Department of Health and Human Services pursuant to Section 1861(t)(2)(B) of the Social Security Action, 107 Stat. 591(1993), 42 U.S.C. 1395x (t)(2)(B), as amended.

(2) "Standard reference compendia" means the United States Pharmacopeia Drug Information, or the American Hospital Formulary Service Drug Information.

B. Every hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan, or any policy of group, family group, blanket, or association health and accident insurance, a self-insurance plan, health maintenance organization, and preferred provider organization, which covers the treatment of cancer in this state shall not exclude coverage for any drug prescribed for the treatment of cancer on the ground that the drug is not approved by the United States Food and Drug Administration for a particular indication if that drug is recognized for treatment of the covered indication in a standard reference compendia or in substantially accepted peer-reviewed medical literature.

C. Coverage for a drug required by this Section shall also include all medically necessary services which are associated with the administration of the drug.

D.(1) This Section shall not be construed to require coverage for a drug if the United States Food and Drug Administration has determined its use to be contra-indicated for the treatment of the current indication.

(2) This Section shall not be construed to create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

E.(1) The provisions of Subsection B of this Section shall not apply to the drugs or services which are furnished in a research trial, if the sponsor of the research trial furnishes the drug or service without charge to participants in the research trial.

(2) The provisions of this Section shall not apply to individually underwritten, guaranteed renewable limited benefit, or supplemental health insurance policies authorized to be issued in the state.

Acts 1997, No. 896, §1; Acts 2003, No. 129, §1, eff. May 28, 2003.

§215.21. Health insurance coverage for diabetes

A. Any hospital, health, or medical expense insurance policy, hospital or medical service contract, health and accident insurance policy, or any other contract of this type providing comprehensive major medical benefits, including a group insurance plan, or any policy of family group, blanket, or association health and accident insurance, a self-insurance plan, an employee welfare benefit plan, or a health maintenance organization subscriber agreement which is is sued or renewed in this state on or after January 1, 1998, or the Office of Group Benefits programs shall provide coverage for the equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a physician or, if applicable, the patient's primary care physician.

B.(1) Every health insurance policy shall include coverage for a one time evaluation and training program per policy for diabetes self-management when medically necessary as determined by a physician and when provided by an appropriately licensed health care professional upon certification by the health care professional providing the training that the insured patient has successfully completed the training. Such programs shall be provided by a health care professional in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. The coverage afforded by this Paragraph shall not exceed five hundred dollars.

(2) In addition to the evaluation and training program provided in Paragraph (1) of this Subsection, coverage for additional diabetes self-management training shall be provided if a physician prescribes such additional training based upon its medical necessity because of a significant change in the insured's symptoms or conditions. This additional coverage shall be limited to one hundred dollars per year and a lifetime limit of two thousand dollars per insured.

(3) The diabetes self-management training provided in Paragraphs (1) and (2) of this Subsection shall be provided by a health care professional within his or her scope of practice after having demonstrated expertise in diabetes care and treatment and after having completed an educational program required by his or her licensing board when that program is in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

C. The benefits provided in this Section shall be subject to the same annual deductibles or co-insurance established for all other covered benefits within a given policy.

D.(1) The provisions of the Section shall not apply to individually underwritten, guaranteed renewable or renewable limited benefit supplemental health insurance policies authorized to be issued in this state.

(2) The provisions of this Section shall not apply to medical benefit plans that are established under and regulated by the Employee Retirement Income Security Act (ERISA) of 1974.

Acts 1997, No. 875, §1; Acts 2001, No. 1178, §2, eff. June 29, 2001; Acts 2003, No. 129, §1, eff. May 28, 2003.

§215.22. Inherited metabolic diseases; coverage for food products

A. Any health, hospital, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan, and a self-insurance plan that provides medical and surgical benefits, which is delivered, issued for delivery, or renewed in this state on or after January 1, 2002, shall provide coverage, subject to applicable deductibles, coinsurance, and copayments, for low protein food products for treatment of inherited metabolic diseases, if the low protein food products are medically necessary and, if applicable, are obtained from a source approved by the health insurance issuer, provided coverage will not be denied if the health insurance issuer does not approve a source.

B. As used in this Section, the following words shall have the following meanings:

(1) "Inherited metabolic disease" shall mean a disease caused by an inherited abnormality of body chemistry. Such diseases shall be limited to:

(a) Glutaric Acidemia.
(b) Isovaleric Acidemia (IVA).
(c) Maple Syrup Urine Disease (MSUD).
(d) Methylmalonic Acidemia (MMA).
(e) Phenylketonuria (PKU).
(f) Propionic Acidemia.
(g) Tyrosinemia.
(h) Urea Cycle Defects.

(2) "Low protein food products" shall mean a food product that is especially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. Low protein food products shall not include a natural food that is naturally low in protein.

C. Coverage provided pursuant to this Section shall not exceed eligible benefits of two hundred dollars per month.

D. The provisions of this Section shall not apply to individually underwritten, guaranteed renewable limited benefit or short-term health insurance policies.

Acts 2001, No. 1013, §1.

§215.23. Prohibited exclusion of coverage of correctable medical conditions on basis of infertility

A.(1) Any health insurance policy, contract, or plan specified in Subsection B of this Section which is issued for delivery, delivered, renewed, or otherwise contracted for in this state on or after January 1, 2002, shall not exclude coverage for diagnosis and treatment of a correctable medical condition otherwise covered by the policy, contract, or plan solely because the condition results in infertility.

(2) This Section shall not be construed to require coverage of the following:

(a) Fertility drugs.

(b) In vitro fertilization or any other assisted reproductive technique.

(c) Reversal of a tubal ligation, a vasectomy, or any other method of sterilization.

B. As used in this Section, a health insurance policy, contract, or plan shall include any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan, a self-insurance plan, and the Office of Group Benefits programs.

Acts 2001, No. 1045, §1.

§215.24. Health insurance coverage for activities performed by a registered nurse first assistant

A. Any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, health maintenance organization subscriber agreement, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan and a self-insurance plan that provides medical and surgical benefits which are delivered, issued for delivery, or renewed in this state on or after January 1, 2004, shall not deny coverage of perioperative services rendered by a registered nurse first assistant if the insurer covers the same such first assistant perioperative services when they are rendered by an advanced practice nurse, a physician assistant, or a physician other than the operating surgeon. Payments to RNFAs for such services shall be subject to the same credentialing and contracting requirements that apply to other health care providers paid for such services.

B. The provisions of this Section shall not apply to individually underwritten, guaranteed renewable limited benefit health insurance policies authorized to be issued in this state. Additionally, the provisions of this Section shall not be construed to prohibit or prevent a health insurer or health maintenance organization from conducting a utilization review pertaining to coverage of the services of a registered nurse first assistant.

C. As used in this Section:

(1) "Perioperative services" means preoperative, intraoperative, and postoperative nursing care provided to surgical patients.

(2) "Recognized program" means a program that addresses all content of the core curriculum for registered nurse first assistant as established by the Association of Operating Room Nurses or its successor organization.

(3) "Registered nurse first assistant" or "RNFA" means a person who has met all of the following requirements:

(a) Is licensed as a registered nurse in accordance with state law.

(b) Is experienced in perioperative nursing.

(c) Has successfully completed a recognized program.

Acts 2003, No. 190, §1.

§215.25. Hearing aid coverage for minor child

A. As used in this Section, "hearing aid" shall mean a nondisposable device that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children.

B. This Section shall apply to the following entities:

(1) Insurers and nonprofit health service plans, including the Office of Group Benefits, that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in this state.

(2) Health maintenance organizations as defined and licensed pursuant to Part XII of Chapter 2 of this Title that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in this state.

C.(1) Notwithstanding the provisions of Act No. 1115 which originated as House Bill No. 1606 of the 2003 Regular Session of the Louisiana Legislature to the contrary, an entity subject to this Section shall provide coverage for hearing aids for a child under the age of eighteen who is covered under a policy or contract of insurance if the hearing aids are fitted and dispensed by a licensed audiologist or licensed hearing aid specialist following medical clearance by a physician licensed to practice medicine and an audiological evaluation medically appropriate to the age of the child.

(2)(a) An entity subject to this Section may limit the benefit payable under Paragraph (1) of this Subsection to one thousand and four hundred dollars per hearing aid for each hearing-impaired ear every thirty-six months.

(b) An insured or enrolled individual may choose a hearing aid that is priced higher than the benefit payable under this Subsection and may pay the difference between the price of the hearing aid and the benefit payable under this Subsection without financial or contractual penalty to the provider of the hearing aid.

(c) In the case of a health insurer or health maintenance organization that administers benefits according to contracts with health care providers, hearing aids covered pursuant to this Section shall be obtained from health care providers contracted with the health insurer or health maintenance organization. Such providers shall be subject to the same contracting and credentialing requirements that apply to other contracted health care providers.

D. This Section does not prohibit an entity subject to the provisions of this Section from providing coverage that is greater or more favorable to an insured or enrolled individual than the coverage required under this Section.

E. The provisions of this Section shall apply to any new policy, contract, program, or plan issued by an entity subject to the provisions of this Section on or after January 1, 2004. Any such policy, contract, program, or plan in effect prior to January 1, 2004, shall convert to the provisions of this Section on or before the renewal date thereof but in no event later than January 1, 2005. Any policy affected by the provisions of this Section shall apply to an insured or participant under such policy, contract, program or plan whether or not the hearing impairment is a pre-existing condition of the insured or participant.

F. The provisions of this Section shall not apply to individually underwritten, guaranteed renewable limited benefit health insurance policies.

Acts 2003, No. 816, §1.

§216. Industrial health and accident insurance

Any insurer authorized to write health and accident insurance in this state shall have power to issue industrial health and accident policies wherein the premium is payable weekly. Every such policy must have printed thereon the words "Industrial Policy" and must contain in substance those provisions in R.S. 22:213 as may be applicable. Insurers issuing policies under this Section shall be subject to all the other applicable provisions of this Part.

Acts 1958, No. 125.

§217. Transportation ticket policy defined

A transportation ticket policy, which may be issued by a health and accident insurer, is any ticket policy sold at stations, ticket offices or travel bureaus by employees of railroads, steamship lines, air lines and other common carriers, or by individuals or employees of persons engaged in selling transportation on such common carriers, having as its dominant feature the protection of the insured from a transportation hazard.

Acts 1958, No. 125.

§218. Construction of policy issued in violation of this part

A policy issued in violation of this Part shall be held valid but shall be construed as provided herein, and when any provision in such a policy is in conflict with any provisions of this Part, the rights, duties and obligations of the insurer, the policyholder and the beneficiary shall be governed by the provisions of this Part.

Acts 1958, No. 125.

§219. Application

A. The falsity of any statement in the application for any policy covered by this Part shall not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer. The insured shall not be bound by any statement unless made in a written application in the case of domestic industrial insurers, and in the case of other insurers, unless a copy of such application is attached to or endorsed on the policy as a part thereof.

B. No alteration of any written application for any such policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

Acts 1958, No. 125.

§220. Notice; waiver

The acknowledgement by any insurer of the receipt of notice given under any policy covered by this Part or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

Acts 1958, No. 125.

§221. Nonapplication to certain policies

A. Nothing in this Part shall apply to or affect:

(1) Any policy of worker's compensation insurance or any policy of liability insurance with or without supplementary expense coverage therein.

(2) Any policy or contract of reinsurance.

(3) Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and health insurance as:

(a) Provide additional benefits in case of death or dismemberment by accident.

(b) Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract.

(4) Fraternal benefit societies, and nonprofit funeral associations regulated under other Parts of this Chapter.

B. The provisions of R.S. 22:212 through 214.1 shall not apply to group or blanket health and accident insurance policies, or to group or blanket policies providing only benefits to cover the cost of legal services and expenses related thereto, including but not limited to counsel's fees, court costs, investigative fees, and expenses incurred by counsel in the investigation of matters, their preparation for trial, and trial; provided that no such policy shall contain any provision relative to notice or proof of loss, or to the time for paying benefits, or to the time in which suit may be brought upon the policy, which in the opinion of the commissioner of insurance is less favorable to the individuals insured than would be permitted by the standard provisions required for individual health and accident policies, or individual policies to cover legal services, as the case may be.

Acts 1958, No. 125. Amended by Acts 1976, No. 205, §1; Acts 1983, 1st Ex.Sess., No. 1, §6; Acts 1993, No. 652, §1, eff. Jan. 1, 1994.

§222. Penalties

A. Any insurer, or any officer or agent thereof, issuing or delivering any health and accident policy on risks in this state in wilful violation of any provision of this Part shall be guilty of a misdemeanor and shall, upon conviction thereof, be fined not more than five hundred dollars or shall be imprisoned for not more than six months, or both, for each offense at the discretion of the court.

B. The commissioner of insurance may revoke the license of any foreign or alien insurer, or of the agent thereof, wilfully violating any provision of this Part.

Acts 1958, No. 125.

§223. Surgical services; place of service

Any insurer of any policy of health and accident insurance issued or having effect in this state, shall pay any claim up to the limit of the policy for any service performed in a licensed ambulatory surgical center as defined in R.S. 40:2133A, providing such service would have been covered if performed as an inpatient service.

Added by Acts 1977, No. 350, §1.

§224. Medicare supplement minimum standards

A.(1) Except as otherwise specifically provided, this Section shall apply to:

(a) All Medicare supplement policies and subscriber contracts delivered or issued for delivery in this state on or after the effective date hereof, and

(b) All certificates issued under group Medicare supplement policies or subscriber contracts which have been delivered or issued for delivery in this state.

(2) Except as otherwise specifically provided in Paragraph F(3), the provisions of this Section are not intended to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons which are not marketed or held to be Medicare supplement policies or benefit plans.

B. For purposes of this Section, the following terms shall have the meaning indicated herein:

(1) "Applicant" means:

(a) In the case of an individual Medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits, and

(b) In the case of a group Medicare supplement policy or subscriber contract, the proposed certificate holder.

(2) "Medicare supplement policy" means a group or individual policy of health insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. 1395 et seq.), or an issued policy under a demonstration project specified in 42 U.S.C. 1395ss(g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursement under Medicare for the hospital, medical, or surgical expenses of a person eligible for Medicare. The term does not include a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

(3) "Certificate" means a certificate issued under a group Medicare supplement policy, which policy has been delivered or issued for delivery in this state.

(4) "Medicare" means the "Health Insurance for the Aged Act", Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

C.(1) The commissioner shall issue reasonable regulations to establish specific standards for policy provisions of Medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with applicable laws of this state. No requirement of the Louisiana Insurance Code relating to minimum required policy benefits, other than the minimum standards contained in this Section, shall apply to Medicare supplement policies. The standards may cover but shall not be limited to:

(a) Terms of renewability.

(b) Initial and subsequent conditions of eligibility.

(c) Nonduplication of coverage.
(d) Probationary periods.
(e) Benefit limitations, exceptions, and reductions.
(f) Elimination periods.
(g) Requirements for replacement.
(h) Recurrent conditions.
(i) Definition of terms.

(2) The commissioner may issue reasonable regulations that specify prohibited policy provisions not otherwise specifically authorized by statute, which in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed for coverage under a Medicare supplement policy.

(3) Notwithstanding any other provisions of law, a Medicare supplement policy shall not deny a claim for losses, incurred more than six months from the effective date of coverage, for a preexisting condition. The policy shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by, or received from, a physician within six months before the effective date of coverage.

D. The commissioner shall issue reasonable regulations to establish minimum standards for benefits, claims payment, marketing practices, compensation arrangements, and reporting practices for Medicare supplement policies. No Medicare supplement insurance policy, contract, or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare.

E.(1) Every insurer providing group Medicare supplement insurance benefits to a resident of this state pursuant to this Section shall file for approval by the commissioner a copy of the master policy and any certificate used in this state in accordance with the filing requirements and procedures applicable to group Medicare supplement policies issued in this state.

(2)(a) Medicare supplement policies shall return to policyholders benefits which are reasonable in relation to the premium charged. The commissioner shall issue reasonable rules and regulations to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

(b) Each entity providing Medicare supplement policies or certificates in this state shall annually file its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss-ratio standards of this state. All filings of rates and rating schedules shall demonstrate that the actual and expected losses in relation to premiums comply with the requirements of this Subpart.[1]

(3) REPEALED BY ACTS 1990, NO. 656, §2.

F.(1) In order to provide for full and fair disclosure in the sale of Medicare supplement policies, no Medicare supplement policy or certificate shall be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made. The commissioner shall prescribe the format and content of the outline of coverage required by this Subsection. In this Subsection, "format" means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type and arrangement of text and captions. The outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy.
(b) A statement of the exceptions, reductions, and limitations contained in the policy.
(c) A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums.
(d) A statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy should be consulted to determine governing contractual provisions.

(2) The commissioner may prescribe by regulation a standard form and the contents of an informational brochure for persons eligible for Medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the commissioner may require by regulation that the informational brochure be provided to any prospective insureds eligible for Medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the commissioner may require by regulation that the prescribed brochure shall be provided to any prospective insureds eligible for Medicare upon request, but in no event later than the time of policy delivery.

(3) The commissioner may promulgate regulations for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for Medicare, other than:

(a) Medicare supplement policies;
(b) Disability income policies;
(c) REPEALED BY ACTS 1997, No. 633, §2, eff. July 3, 1997.
(d) REPEALED BY ACTS 1997, No. 633, §2, eff. July 3, 1997.

(4) The commissioner may further promulgate reasonable regulations to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, subscriber contracts, or certificates by persons eligible for Medicare.

G. Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this Subsection shall be paid directly to the applicant by the insurer in a timely manner.

H. Every insurer, health care service plan, or other entity providing Medicare supplement insurance or benefits in this state shall provide a copy of any Medicare supplement advertisement intended for use in this state, whether through written, radio, or television medium, to the commissioner for his review and approval to the extent permitted under the Insurance Code, particularly under R.S. 22:1215.

I. Rules and regulations promulgated pursuant to this Section shall be subject to the Administrative Procedure Act.

J. In addition to any other applicable penalties for violation of provisions of the Louisiana Insurance Code, the commissioner may require an insurer who violates any provision of this Section or regulations promulgated pursuant to this Section to cease marketing any Medicare supplement policy or certificate in this state which is related directly or indirectly to a violation, or may require such insurer to take such actions as are necessary to comply with the provisions of this Section, or both.

K. Payment of premiums for Medicare supplement policies shall only be made as follows:

(1) By check, money order, or bank draft made payable to the insurer; or

(2) By cash, provided that an insurer's receipt which binds the insurer for receipt of such premium shall be issued to the insured.

L. The commissioner may adopt reasonable regulations as are necessary to conform Medicare supplement policies and certificates with the requirements of federal law and regulations promulgated thereunder, including but not limited to:

(1) Requiring refunds or credits if the policies or certificates do not satisfy loss ratio requirements.

(2) Establishing a uniform methodology for calculating and reporting loss ratios.

(3) Assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance.

(4) Establishing a process for the approval or disapproval of policy forms and certificate forms and proposed premium increases.

(5) Establishing a policy for holding public hearings prior to the approval of any premium increase.

(6) Establishing standards for Medicare Select policies and certificates.

Added by Acts 1981, No. 146, §1, eff. Jan. 1, 1982; Acts 1989, No. 447, §1, eff. Sept. 1, 1989; Acts 1990, No. 656, §§1 and 2; Acts 1992, No. 428, §1, eff. July 1, 1992; Acts 1997, No. 633, §§1, 2 eff. July 3, 1997.

[1]As appears in enrolled bill.

§225. Discrimination against volunteer firemen prohibited

No insurer doing business in this state who issues an individual or a group policy of hospitalization or major medical coverage to an insured who is a volunteer fireman shall charge a higher premium rate for the insured based solely on the insured's activities as a volunteer fireman, unless the individual or group policy is required to pay benefits for occupational disease or injury, or both.

Acts 1984, No. 444, §1.

§226. Employer-provided health plan; limitation to specific pharmacies prohibited; penalty

A. No employer who provides pharmacy services including prescription drugs to any employee or retiree of such employer, as part of any health insurance or health maintenance program, shall knowingly:

(1) Require the employee or retiree to obtain prescription drugs from a mail order pharmacy as a condition of obtaining payment for such drugs; or

(2) Impose upon an employee or retiree who does not utilize a designated mail order pharmacy a copayment fee or other condition not imposed upon employees or retirees who utilize the designated mail order pharmacy.

B. The provisions of this Section shall not apply to any policies, contracts, programs, or plans which are provided by an employer to its employees pursuant to any agreement, whether or not in the form of a binding collective bargaining agreement.

C. Any person violating the provisions of this Section, upon conviction shall be fined not more than five hundred dollars.

Acts 1988, No. 481, §1.

§227. Insurance pending adoption

A. Any unmarried child who is placed in the home of an insured pursuant to an adoption placement agreement executed with an adoption agency licensed in accordance with the Child Care Facility and Child-Placing Agency Licensing Law (R.S. 46:1401 et seq.), or corresponding law of any other state, shall be considered a dependent child of the insured from the date of placement in the home of the insured under the provisions of any individual, group, family group, blanket, or association health and accident insurance policy issued in this state. Coverage available under the policy shall be in accordance with the provisions of the contract of insurance.

B. Any unmarried child who is placed in the home of an insured pursuant to Part III of Chapter 1 of Code Title VII of Code Book I of Title 9 of the Louisiana Revised Statutes of 1950, following execution of an act of voluntary surrender in favor of the insured or the insured's legal representative shall be considered a dependent child of the insured under the provisions of any individual, group, family group, blanket, or association health and accident insurance policy issued in this state from the date on which the act of voluntary surrender becomes irrevocable. The clerk of the court having jurisdiction of the adoption matter is hereby authorized to issue, upon request of the insured or the insured's legal representative, a certificate setting forth the name of the child, the date of execution of the act of voluntary surrender, and the date on which the act of voluntary surrender became irrevocable. Coverage available under the policy shall be in accordance with the provisions of the contract of insurance.

Acts 1988, No. 746, §1; Acts 2003, No. 129, §1, eff. May 28, 2003.

§228. Cancellation prohibited after claim for terminal, incapacitating, or debilitating condition

A. No group, individual, family group, or blanket health insurer shall unilaterally cancel a policy after the insurer has received any covered claim or notice of any covered claim for a terminal, incapacitating, or debilitating condition if the insured continues to meet all other eligibility criteria as provided under Part VI-C of this Chapter.

B. In this Section "terminal, incapacitating, or debilitating condition" means any aggressive malignancy, chronic end stage cardiovascular or cerebral vascular disease, diabetes and its long-term associated complications, pregnancy, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), or any other disease, illness, or condition which a physician diagnoses as terminal, or any mental or physical handicap which renders a person incapable of self-employment, provided that the handicapped person is chiefly dependent upon the policyholder, employee, or member for support and maintenance.

C. This Section shall not be construed to prohibit the insurer from increasing the rate for the group, as provided in R.S. 22:228.1 through 228.6.

D. This Section shall not be construed to prohibit an insurer from discontinuing health insurance coverage pursuant to R.S. 22:250.7 and 250.13.

Acts 1989, No. 269, §1; Acts 1991, No. 777, §1, eff. Sept. 30, 1991; Acts 1999, No. 127, §1, eff. June 9, 1999; Acts 2001, No. 272, §1, eff. Jan. 1, 2002.

§228.1. Health insurance plans subject to rate limitations

A. The provisions of R.S. 22:228.1 through 228.6 shall apply to any health benefit plan which provides coverage to a small employer except the following:

(1) An Archer medical savings account that meets all requirements of Section 220 of the Internal Revenue Code of 1986.

(2) A health savings account that meets all requirements of Section 223 of the Internal Revenue Code of 1986.

B. Definitions. Notwithstanding any law to the contrary, the following terms shall be defined as follows:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries that a small employer carrier is in compliance with the provisions of R.S. 22:228.2, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health benefit plans.

(2) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(3) "Carrier" means an insurance company, including a health maintenance organization as defined and licensed to engage in the business of insurance under Part XII of Chapter 2 of this Title, which is licensed or authorized to issue individual, group, or family group health insurance coverage for delivery in this state.

(4) "Case characteristics" mean demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, which are considered by the carrier in the determination of premium rates for the small employer. Claim experience, health status and duration of coverage since issue are not case characteristics for the purposes of this Section.

(5) "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer carrier.

(a) A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans:

(i) Are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groupings of small employers for such small employer carrier;

(ii) Have been acquired from another small employer carrier as a distinct grouping of plans; or

(iii) Are provided through an association with membership of not less than twenty-five small employers which has been formed for purposes other than obtaining insurance.

(b) A small employer carrier may establish no more than two additional groupings under each of the items in Subparagraph (a) of Paragraph (5) of this Subsection on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.

(c) The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

(6) "Health benefit plan", "plan", or "health insurance coverage" means benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization, or health maintenance organization contract offered by a health insurance issuer. However, a "health benefit plan" shall not include limited benefit and supplemental health insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

(7) "Health savings accounts" are those accounts for medical expenses authorized by 26 U.S.C.A. §220, et seq.

(8) "High deductible health plan" means a high deductible health plan or policy that is qualified to be used in conjunction with a health savings account, medical savings account, or other similar program authorized by 26 U.S.C.A. §220, et seq.

(9) "Index rate" means for each class of business for small employers with similar case characteristics the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(10) "Medical savings account policy" means a high deductible health plan which is qualified to be used in conjunction with a medical savings account as provided in 26 U.S.C.A. §220, et seq.

(11) "New business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefits plans with the same or similar coverage.

(12) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(13) "Small employer" means any person, firm, corporation, partnership, or association actively engaged in business which, on at least fifty percent of its working days during the preceding year, employed no less than three nor more than thirty-five eligible employees. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. An employer group of one shall be considered individual insurance under this Section.

(14) "Small employer carrier" means any carrier which offers health benefit plans covering the employees of a small employer.

C. Group and individual high deductible health plans are excluded from the provisions of R.S. 22:228.1 through 228.6.

Acts 1991, No. 777, §2, eff. Sept. 30, 1992; Acts 1993, No. 54, §1; Acts 2001, No. 272, §1, eff. January 1, 2002; Acts 2003, No. 659, §1; Acts 2004, No. 663, §1.

§228.2. Restrictions relating to premium rates; health insurance

A. Premium rates for group health benefit plans subject to R.S. 22:228.1 through 228.5 shall be subject to the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent.

(2) For a class of business, the premium rates charged during a rating period to any employer with similar case characteristics for the same or similar coverage, or the rates which could be charged to such employer under the rating system for that class of business, whether new coverage or renewal coverage, shall not vary from the index rate by more than thirty-three percent of the index rate.

(3) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate.

(b) An adjustment, not to exceed twenty percent annually and adjusted pro rata for rating periods of less than one year, due to one or a combination of the following: claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the carrier's rate manual for the class of business.

(c) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

B. Nothing in this Section is intended to affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status, or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

C. A small employer carrier shall not involuntarily transfer a small employer into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration since issue.

Acts 1991, No. 777, §2, eff. Sept. 30, 1992; Acts 2001, No. 272, §1, eff. Jan. 1, 2002.

§228.3. REPEALED BY ACTS 1997, No. 1138, §2, eff. July 14, 1997.

§228.4. Disclosure of rating practices and renewability provisions

A. Each carrier shall make reasonable disclosure in solicitation and sales materials provided to small employers of the following:

(1) The extent to which premium rates for a specific small employer are established or adjusted due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer.

(2) The provisions concerning the carrier's right to change premium rates and the factors, including case characteristics, which affect changes in premium rates.

(3) A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans.

(4) The provisions relating to renewability of coverage.

B. Each carrier shall provide a reasonable explanation of any rate increase no less than forty-five days prior to the effective date of such increase. Such explanation shall indicate the contributing factors resulting in an increased premium, which may include but not be limited to experience, medical cost, and demographic factors.

Acts 1991, No. 777, §2, eff. Sept. 30, 1992; Acts 2001, No. 272, §1, eff. Jan. 1, 2002.

§228.5. Maintenance of records

A. Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting description of its rating practices and renewal underwriting practices, including information and documentation which demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

B. Each small employer carrier shall file each March first with the commissioner an actuarial certification that the carrier is in compliance with this Section and that the rating methods of the carrier are actuarially sound. A copy of such certification shall be retained by the carrier at its principal place of business.

C. A small employer carrier shall make the information and documentation described in Subsection A of this Section available to the commissioner upon request. The information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

Acts 1991, No. 777, §2, eff. Sept. 30, 1992.

§228.6. Modified community rating; health insurance premiums; compliance with rules and regulations

A. Each small group and individual health and accident insurer shall maintain at its principal place of business a complete and detailed description of its rating practices and a renewal underwriting description of its rating practices and renewal underwriting practices, including information and documentation which demonstrate that its rating methods and practices are in full and complete compliance with the rules and regulations promulgated by the Department of Insurance for a modified community rating system for health insurance premiums.

B.(1) The Department of Insurance shall promulgate regulations no later than January 1, 1994, that provide criteria for the community rating of premiums for any hospital, health, or medical expense insurance policy, hospital or medical service contract, health and accident policy or plan, or any other insurance contract of this type, that is small group or individually written.

(2)(a) The regulations shall place limitations upon the following classification factors used by any insurer or group in the rating of individuals and their dependents for premiums:

(i) Medical underwriting and screening.

(ii) Experience and health history rating.

(iii) Tier rating.

(iv) Durational rating.

(b) The premiums charged shall not deviate according to the classification factors in Subparagraph (a) of this Paragraph by more than plus or minus thirty-three percent for individual health insurance policies or subscriber agreements. In no event shall the increase in premiums for a small employer group policy vary from the index rate by plus or minus thirty-three percent.

(3) The following classification factors may be used by any small group or individual insurance carrier in the rating of individuals and their dependents for premiums:

(a) Age.

(b) Gender.

(c) Industry.

(d) Geographic area.

(e) Family composition.

(f) Group size.

(g) Tobacco usage.

(h) Plan of benefits.

(i) Other factors approved by the Department of Insurance.

C. Any small group and individual insurance carrier that varies rates by health status, claims experience, duration, or any other factor in conflict with the regulations promulgated by the Department of Insurance shall establish a phase-out rate adjustment as of the first renewal date on or after January 1, 2002, for each entity insured by the carrier in order to come into compliance with this Section pursuant to the regulations promulgated by the Department of Insurance.

D. The provisions of this Section shall not apply to individually underwritten limited benefit and supplemental health insurance policies.

Acts 1993, No. 655, §1; Acts 1995, No. 593, §1; Acts 1995, No. 1173, §1; Acts 1997, No. 1165, §1; Acts 2001, No. 272, §1, eff. January 1, 2001; Acts 2004, No. 426, §1.

§228.7. Coverage for dental procedures; anesthesia and hospitalization

A. Every hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, health and accident insurance policy, or any policy of group, family group, blanket, or association health and accident insurance, a self-insurance plan, health maintenance organization, and preferred provider organization, and the Office of Group Benefits programs, which are delivered or issued for delivery in this state shall provide benefits for anesthesia when rendered in a hospital setting and for associated hospital charges when the mental or physical condition of the insured requires dental treatment to be rendered in a hospital setting.

B. An insurer under this Section may require prior authorization for hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other covered medical conditions. For a patient to satisfy the criteria of Subsection A, a dentist shall consider the Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, as utilization standards for determining whether performing dental procedures necessary to treat the particular condition or conditions of the patient under general anesthesia constitutes appropriate treatment.

C. The provisions of this Section shall not apply to treatment rendered for temporal mandibular joint (TMJ) disorders.

D. An insurer under this Section may restrict coverage to include only procedures performed by:

(1) A fully accredited specialist in pediatric dentistry or other dentists fully accredited in a recognized dental specialty for which hospital privileges are granted.

(2) A dentist who is certified by virtue of completion of an accredited program of post-graduate hospital training to be granted hospital privileges.

(3) A dentist who has not yet satisfied the certification requirements, but has been granted hospital privileges as of January 1, 1998.

E. The provisions of this Section shall not apply to individually underwritten, guaranteed renewable or renewable limited benefit supplemental health insurance policies, or limited benefit policies authorized to be issued in this state.

Acts 1997, No. 1125, §1, eff. Jan. 1, 1998; Acts 1999, No. 1188, §1; Acts 2001, No. 1178, §2, eff. June 29, 2001; Acts 2003, No. 129, §1, eff. May 28, 2003.

§228.8. Local government contributions toward medical savings accounts, health savings accounts, and similar accounts

Notwithstanding any other provision of law to the contrary, the governing authority of any parish, municipality, or other political subdivision of the state may establish and contribute funds toward medical savings accounts, health savings accounts, and similar accounts authorized by federal law for its employees. Such accounts may be used in conjunction with high deductible health plans for such employees. However, any governing authority of a parish, municipality, or other political subdivis ion of the state that chooses to establish medical savings accounts, health savings accounts, or other similar accounts authorized by federal law for its employees under the provisions of this Section shall contract with a licensed third- party administrator to administer the medical or health insurance program.

Added by Acts 2004, No. 890, §1.

§229. Health and accident insurers; rate increases

Health and accident insurers shall not increase their premium rates during the initial twelve months of coverage and not more than once in any six-month period following the initial twelve-month period, for any policy, rider, or amendment issued in or for residents of the state, no matter the date of commencement or renewal of the insurance coverage. This Section does not affect increases in the premium amount due to the addition of a newly covered person or a change in age or geographic location of an individual insured or policyholder or an increase in the policy benefit level.

Acts 1990, No. 636, §1; Acts 1991, No. 848, §1; Acts 1993, No. 297, §1; Acts 1995, No. 418, §1.

§229.1. Covered claim; prohibition of cancellation

No health and accident insurer may unilaterally cancel a policy of insurance except for nonpayment of premiums, increase the premium for such policy, or reduce the benefits provided by such insurance policy after receipt or notice of any covered claim. The insurer may cancel the policy, as otherwise provided by law, after the claimant has been discharged from treatment for that condition and no further claims for that condition are expected, provided there has been no other receipt or notice of claim under that policy. This Section shall not prohibit any group health and accident insurer or any individual accident and health insurer from increasing its premium if the increase is applicable to all members of the group insurance plan, or all insureds who have the same individual accident and health plan or policy.

Acts 1993, No. 944, §1; Acts 1997, No. 1471, §1.

§229.2. Discrimination against recovered or rehabilitated alcoholics; prohibited

No insurer doing business in the state that issues an individual or group policy of hospitalization or major medical coverage shall discriminate against any person solely on the basis that he is a recovered or rehabilitated alcoholic by denial of coverage or benefits, assessment or collection of higher premiums, or cancellation of the policy. The insurer, at its own costs, may require that the person submit to reasonable medical testing to determine the diagnosis of the person as an alcoholic. This Section shall not prohibit the underwriting of health conditions which arise from alcoholism. The provisions of this Section shall not apply to individually underwritten, guaranteed renewable or renewable limited benefit supplemental health insurance policies authorized to be issued in this state or to medical benefit plans that are established under and regulated by the Employment Retirement Income Security Act of 1974.

Acts 1997, No. 1481, §1.

§229.3. R.S. 22§229.3 as enacted by Acts 1997, No. 1481, §1, relative to impact reports on mandated health insurance benefits, was redesignated as R.S. 24§603.1.

§230. Disability loss of income policies

A. An individual or group disability loss of income policy to provide loss of income protection against total disability may be issued in this state consistent with the definitions and provisions of this Section.

B. Total disability may be defined in relation to the inability of the person to perform duties but shall not be based solely upon an individual's inability to:

(1) Perform "any occupation whatsoever", "any occupational duty", or "any and every duty of his occupation"; or

(2) Engage in any training or rehabilitation program.

C. A general definition of total disability in such a policy shall not be more restrictive than one requiring the individual to be totally disabled from engaging in any employment or occupation for which he is, or becomes, qualified by reason of education, training, or experience and which provides him with substantially the same earning capacity as his former earning capacity prior to the start of the disability.

D. An insurer may specify the requirement of the complete inability of the individual to perform all of the substantial and material duties of his regular occupation or words of similar import.

E. An insurer may require care by a physician other than the insured or a member of the insured's family.

Acts 1990, No. 879, §1.

{{**NOTE**: SEE ACTS 1990, NO. 879, §2.}}

§230.1. Coverage for rehabilitative physical therapy, occupational therapy, and speech and language pathology therapy; optional coverage

A. Each group, family group, blanket, or association health and accident insurance policy including any insurance program, except the Office of Group Benefits programs, covering the state of Louisiana or any of its subdivisions, departments, or agencies or any of the governing boards or authorities of any state university or college or any public elementary or secondary school system, which is delivered or issued for delivery in this state shall include as an option to be exercised by the policyholder, as defined therein, covered benefits for speech and language pathology therapy, physical therapy, rehabilitative services, and occupational therapy.

B. These benefits shall be payable when the rehabilitative treatment or services are rendered by a licensed speech pathologist or licensed audiologist in the case of speech or language therapy, or by a licensed physical therapist in the case of physical therapy, or when the rehabilitative treatment or services are rendered by a physician licensed in this state, or when such treatment or services are rendered by a licensed occupational therapist or by a licensed chiropractor.

C. The effective date for policies, contracts, programs, or plans specified in Subsection A of this Section shall be as provided herein. The provisions of this Section shall apply to all new policies, contracts, programs, or plans issued on or after January 1, 1991. Any policies, contracts, or plans in effect on December 31, 1990, shall, on the anniversary date of such coverage, be covered in accordance with this Section; however, all existing policies shall be converted to conform to the provisions of this Section no later than January 1, 1992.

Acts 1990, No. 1071, §1; Acts 1991, No. 761, §1; Acts 1993, No. 703, §1; Acts 2001, No. 1178, §2, eff. June 29, 2001; Acts 2003, No. 129, §1, eff. May 28, 2003.

§230.2. Policies, group health and accident; conversion

A. Effective January 1, 1998, health coverage subject to fees assessed under R.S. 22:239.1(A)(2) shall be exempted from mandatory issuance of a converted policy. Conversion policies issued prior to January 1, 1998, shall continue to be subject to the provisions of this Section.

B.(1) A group policy or group certificate delivered or issued for delivery in this state by: an insurer; a nonprofit mutual association which is engaged exclusively in the furnishing of hospital services and medical or surgical benefits; a health maintenance organization; a self-insured plan that provides, on an expense-incurred basis, hospital, surgical, or major medical expense insurance; or any combination thereof, shall provide that an employee or member whose insurance under the group policy has been terminated for any reason and who has been continuously insured under the group policy and under any group policy providing similar benefits that the terminated group policy replaced, for at least three months immediately prior to termination, shall be entitled to have issued to him by the insurer a policy or certificate of health and accident insurance, hereafter referred to in this Section as a "converted policy".

(2) An employee or member shall be denied a converted policy if termination of the prior insurance under the group policy occurred because of fraud or discontinuance of the prior group policy by replacement of similar group coverage within thirty-one days after discontinuance.

C. The written application for the converted policy shall be completed, and the first premium shall be paid to the insurer not later than thirty-one days after notice to the insured of the termination of the prior group coverage.

D. The converted policy shall be issued without evidence of insurability.

E.(1) The premium for the converted policy shall be determined in accordance with premium rates applicable to the age, class of risk, and type and amount of insurance coverage provided in the converted policy of the person to be covered. However, the premium for the converted policy may not exceed the premium charged by the Louisiana Health Plan at the time of conversion, adjusted for differences between benefit levels for the converted policy and the policy offered by the Louisiana Health Plan.

(2) The actual or expected experience under converted policies may be combined with the experience under group policies for the purposes of the determination of premium and loss experience by the insurer and the establishment of adequate premium rate levels for group coverage.

(3) For purposes of this Section, a conversion policy shall not be denied because a person is or may be eligible for benefits pursuant to R.S. 22:240. In the event that the Louisiana Health Plan does not issue policies, or has not done so by the effective date of this Section,[1] benefit and premium levels for conversion policies under this Section shall be based upon those proposed by the Louisiana Health Plan, if any, or determined in accordance with the mechanisms established by R.S. 22:240.

F. The effective date of the converted policy shall be the day following the termination of insurance under the group policy.

G. The converted policy shall provide insurance coverage for the employee or member and the dependents of the employee or member who were covered by the group policy for at least three months prior to the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent.

H. The insurer shall not be required to issue, maintain, or renew a converted policy for an employee or member if any of the following apply to the employee or member:

(1) The person is covered for similar benefits by another hospital, surgical, medical, or major medical insurance policy; hospital or medical service subscriber contract; medical practice or other prepayment plan; or any other plan or program.

(2) The person is eligible for similar benefits, whether or not actually provided coverage, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis.

(3) Similar benefits are provided for or are available to the person under any state or federal law.

(4) The person legally resides outside the health maintenance organization service area.

I.(1) A converted policy may include a provision under which the insurer may request information, in advance of any premium due date, of any person covered thereunder as to whether:

(a) The person is covered for similar benefits by another hospital, or major medical expense insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or any other plan or program.

(b) The person is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis.

(c) Similar benefits are provided for or are available to the person under any state or federal law.

(2) The converted policy may provide that the insurer may refuse to renew the policy of any person only for one of the following reasons:

(a) The converted policyholder fails to provide the information requested pursuant to Paragraph (1) of this Subsection.

(b) Fraud or material misrepresentation by the member or employee in applying for any benefits under the converted policy.

(c) Eligibility of the insured person for coverage under Medicare, Title XVIII of the Social Security Act, as added by the Social Security Amendments of 1965, or as later amended or superseded, or under any other state or federal law providing for those benefits provided by the converted policy.

(d) Any other reason approved by the commissioner of insurance.

J. An insurer under this Section shall not be required to issue a converted policy that provides benefits in excess of those provided under the preceding group policy.

K. In determining whether any preexisting condition precludes coverage for a specific benefit in the converted policy, credit shall be given for the time the person was covered under the group policy.

L.(1) Subject to any provision and condition of this Section, the employee or member shall be entitled to obtain a converted policy providing major medical coverage under a plan providing substantially similar benefits to those offered in R.S. 22:240(A) through (E). If the benefit levels required in R.S. 22:240(A) through (E) exceed the benefit levels provided under the prior group insurance policy, the converted policy may offer benefits which are substantially similar to those provided under the prior group policy.

(2) The converted policy shall include coverage from birth for a newborn if the converted policy includes dependent coverage. The converted policyholder may add coverage for a newborn from birth to a policy without dependent coverage by paying the additional premium and notifying the insurer within thirty-one days of the birth of the newborn. This Paragraph shall only apply to the biological child of the policyholder.

M. An insurer may, at its option, also offer alternative plans for group health and accident conversion in addition to the converted policy required by this Section.

N. The conversion privilege provided in this Section shall also be available to any of the following:

(1) To the surviving spouse, if any, at the death of the employee or member, with respect to the spouse and the children whose coverage under the group policy terminates by reason of such death, otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or, if the group policy provides for continuation of coverage for the dependent following the death of the employee or member.

(2) To the spouse of the employee or member upon termination of coverage of the spouse, if the employee or member remains insured under the group policy, by reason of ceasing to be a qualified family member under the group policy, with respect to the spouse and the children whose coverages under the group policy terminate at the same time.

(3) To a minor solely with respect to himself upon termination of coverage by reason of ceasing to be a qualified family member under the group policy, if the conversion privilege is not otherwise provided in this Subsection with respect to such termination.

O. If the benefit levels required in this Section exceed the benefit levels provided under the prior group policy, the converted policy may offer benefits which are substantially similar to those provided under the prior group policy.

P. Any insurer of health and accident insurance may elect to provide group health and accident insurance coverage instead of issuing an individual converted policy.

Q. A notification of the right to a converted policy shall be included in each certificate of coverage for health and accident insurance.

R. This Section may not require conversion on termination of eligibility for a policy or contract that provides benefits for specified diseases or for accidental injuries only, or to disability income, Medicare supplement, hospital indemnity, limited benefit, nonconventional, or excess insurance policies.

Acts 1992, No. 342, §1; Acts 1992, No. 534, §1; Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 445, §1, eff. June 18, 1999.

[1]As appears in enrolled bill. (Subsection enacted in 1992)

§230.3. REPEALED BY ACTS 2003, No. 1157, §2, eff. Jan. 1, 2004.

§230.4. Health coverage; participants in clinical trials

A. As used in this Section, the following terms and phrases shall have the following meanings unless the context clearly indicates otherwise:

(1) "Cooperative group" means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. "Cooperative group" includes the following:

(a) NCI funded clinical cooperative groups such as the Southwestern Oncology Group, Radiation Therapy Oncology Group, etc.

(b) The NCI Community Clinical Oncology Program and its minority-based affiliates.

(2) "FDA" means the Federal Food and Drug Administration.

(3) "Health insurance coverage" means benefits consisting of medical care provided or arranged for directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer.

(4) "Health insurance issuer" means an insurance company, including a health maintenance organization as defined and licensed pursuant to Part XII of Chapter 2 of this Title, unless preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974. For purposes of this Section and Part VI-D of Chapter 1 of this Title, a "health insurance issuer" shall include the State Employees Group Benefits Program.

(5) "Member" means a policyholder, subscriber, insured, or certificate holder or a covered dependent of a policyholder, subscriber, insured, or certificate holder.

(6) "Multiple project assurance contract" means a contract between an institution and the United States Department of Health and Human Services office for protection from research risks which contract defines the relationship of the institution to the office for protection from research risks and which sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

(7) "NCI" means the National Cancer Institute.

(8) "NIH" means the National Institutes of Health.

(9) "Patient" means a policyholder, subscriber, or certificate holder or a covered dependent of a policyholder, subscriber, or certificate holder.

(10) "Patient cost" means any of the cost of health care services, treatments, or testing that are incurred as part of the protocol treatment being provided to the patient for purposes of the clinical trial. "Patient cost" shall not include the following items:

(a) The cost of non-health care services that a patient may be required to receive as a result of the treatment being provided pursuant to the clinical trial.

(b) Costs associated with managing the research data associated with the clinical trial.

(c) The cost of such investigational devices or drugs not required to be covered under R.S. 22:215.20.

(d) Costs not otherwise covered under the insured, subscriber, or enrollee's policy, plan, or contract of coverage for noninvestigational treatments.

B. The provisions of this Section shall apply to all health insurance coverage issued by a health insurance insurer for delivery in this state, except limited benefit and short duration health insurance policies that provide cash benefits directly to the insured when hospitalized, injured, or ill.

C. This Section shall not apply to any policy or plan or contract paid for under Title XVII or Title X of the federal Social Security Act.

D. Each policy or plan subject to the provisions of this Section shall provide coverage for patient costs incurred as a result of a treatment being provided in accordance with a clinical trial for cancer except any applicable copayment, deductible, or coinsurance amounts. Such costs shall include coverage for costs incurred for health-related services not otherwise required under R.S. 22:215.20.

E. Costs of investigational treatments and costs of associated protocol-related patient care shall be covered if all of the following criteria are met:

(1) The treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer.

(2) The treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer.

(3) The treatment is being provided in accordance with a clinical trial approved by one of the following entities:

(a) One of the United States NIH.

(b) A cooperative group funded by one of the NIH.

(c) The FDA in the form of an investigational new drug application.

(d) The United States Department of Veterans Affairs.

(e) The United States Department of Defense.

(f) A federally funded general clinical research center.

(g) The Coalition of National Cancer Cooperative Groups.

(4) The proposed protocol has been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks.

(5) The facility and personnel providing the protocol provided the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.

(6) There is no clearly superior, non-investigational approach.

(7) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative.

(8) The patient has signed an institutional review board-approved consent form.

F. Any entity seeking coverage for treatment in a clinical trial approved by an institutional review board shall post electronically, and keep up-to-date, a list of the cancer clinical trials meeting these requirements and the list shall include the following for each clinical trial:

(1) The phase for which the trial is approved.

(2) The entity approving the trial which renders it eligible for reimbursement.

(3) The cancer or cancers for which the trial is approved.

(4) The estimated number of participants in the trial.

G. The provisions of this Section shall not be construed to affect compliance or coverage for off-label use of drugs not directly affected by this Section.

H. The commissioner may promulgate necessary rules and regulations, pursuant to R.S. 22:3, to provide for submission of annual reports by health insurers describing clinical trials for which coverage was provided to insureds, subscribers, or enrollees.

Acts 1999, No. 1357, §1, eff. July 12, 1999; Acts 2001, No. 1178, §2, eff. June 29, 2001.

§230.5. Statutory mandates; actuarial cost analysis; periodic reevaluation; moratorium on additional mandates

A. For purposes of this Section:

(1) "Statutory mandate" shall mean any provision of law that requires a health insurer, health maintenance organization, or preferred provider organization to provide or offer coverage for mandated benefits or mandated options to its insureds, enrollees, or subscribers.

(a) Statutory mandates shall include R.S. 22:215.1(B), 215.5, 215.8, 215.10, 215.11, 215.14, 215.15, 215.16, 215.20, 215.21, 228.7, 230.1, 230.4, 669, and 2004.1.

(b) Statutory mandate shall not include any federally mandated benefit or mandated option.

(2) "Actuarial cost analysis" shall mean an analysis conducted by the Department of Insurance of the costs associated with the statutory mandate, including but not limited to the actual premium cost of the specific mandate and the effect of the mandate on insurance premiums charged to the citizens of this state.

(3) "Periodic reevaluation" shall mean evaluation by the House and Senate Committees on Insurance of each statutory mandate and of the relevant actuarial cost analysis conducted by the Department of Insurance as required by Subsection B of this Section.

B.(1) Each statutory mandate specified in Subparagraph (A)(1) (a) of this Section shall undergo an actuarial cost analysis, the results of which shall be reported to the House and Senate Committees on Insurance prior to commencement of the 2003 Regular Session of the Legislature for their periodic reevaluation.

(2) Any statutory mandate enacted or reenacted after January 1, 2001, shall undergo an actuarial cost analysis, the results of which shall be reported to the House and Senate Committees on Insurance prior to commencement of the fourth regular session of the legislature after the regular session in which it was enacted or reenacted for their periodic reevaluation.

C.(1) Notwithstanding any other provision of law to the contrary, a health insurance issuer shall not be required to deliver, issue, or renew a health benefit plan on or after January 1, 2004, and before December 31, 2008, that includes any additional mandate benefit or mandated option beyond those statutory requirements in effect for health benefit plans on July 2, 2003. This Subsection shall apply to any health benefit plan delivered or issued for delivery in this state, including any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare plan, health and accident insurance policy, or any policy of group, family group, blanket, or franchise health and accident insurance, self-insurance plan, health maintenance organization, preferred provider organization, or the Office of Group Benefits.

(2) Nothing in this Subsection shall be construed to prohibit an employer from electing to expand coverage on any group or individual health benefit plan or policy covering the employer and the employees of the employer.

(3) Nothing in this Subsection shall be construed to prohibit a health insurance issuer from electing to expand coverage on any group or individual health benefit plan.

D. Nothing in this Section shall affect the fiscal impact report required by R.S. 24:603.1 to be attached to any legislation mandating health insurance benefits or options prior to its consideration by any committee of either house of the legislature.

E. Nothing in this Section shall be construed to allow a health benefit plan policy delivered, issued, or renewed after July 2, 2003, to suspend, limit, or modify any mandates in effect on that date.

Acts 2001, No. 1133, §1; Acts 2003, No. 1115, §1, eff. July 2, 2003.

NOTE: See Acts 2003, Nos. 816 and 829, §§2 and 3.

§230.6. Continuity of care of health care services

A. For purposes of this Subsection:

(1) "Covered health care services" means services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease that are either covered and payable under the terms of health insurance coverage or required by law to be covered.

(2) "Enrollee" or "insured" means an individual who is enrolled in or insured by a health insurance issuer for health insurance coverage.

(3) "Health care provider" or "provider" means a physician licensed by the Louisiana State Board of Medical Examiners to practice medicine or other health care practitioner licensed, certified, or registered to perform specified health care services consistent with state law subject to direct supervision by such a licensed physician.

(4) "Health insurance issuer" means any entity that offers health insurance coverage through a policy or certificate of insurance subject to state law that regulates the business of insurance. For purposes of this Part, a "health insurance issuer" shall include a health maintenance organization, as defined and licensed pursuant to Part XII of Chapter 2 of this Title, and nonfederal government plans subject to the provisions of Part VI-D of this Chapter, including the Office of Group Benefits.

(5) "Health insurance issuer liability" means the contractual liability of a health insurance issuer for covered health care services pursuant to the plan or policy provisions between the enrollee or insured and the health insurance issuer.

(6) "Life-threatening illness" means a severe, serious, or acute condition for which death is probable.

B. In the event a contract or agreement between a health insurance issuer and health care provider is terminated, the health care provider shall notify the health insurance issuer of any enrollee or insured who has begun a course of treatment by the provider before the effective date of the termination. Based on this notice from the health care provider, the health insurance issuer shall notify the enrollee or insured of a termination of a health care provider from a health insurance issuer's network and the enrollee's or insured's right to continuity of care. The following provisions of this Subsection shall be applicable whether such termination is initiated by the health insurance issuer or the health care provider.

(1) In the event an enrollee or insured has been diagnosed as being in a high-risk pregnancy or is past the twenty-fourth week of pregnancy, the enrollee or insured shall be allowed to continue receiving covered health care services, subject to the consent of the treating health care provider, through delivery and postpartum care related to the pregnancy and delivery.

(2) In the event an enrollee or insured has been diagnosed with a life-threatening illness, the enrollee or insured shall be allowed to continue receiving covered health care services, subject to the consent of the treating health care provider, until the course of treatment is completed, not to exceed three months from the effective date of such termination.

(3) In the event a treating health care provider advises the health insurance issuer of an enrollee or insured who meets the criteria of Paragraph (1) or (2) of this Subsection, the health insurance issuer shall continue payment of the health insurance issuer liability to the health care provider that was in effect prior to the termination of the contract or agreement with such health care provider. In addition, the contractual requirements for the health care provider to follow the health insurance issuer's utilization management and quality management policies and procedures shall remain in effect for the applicable period specified in Paragraph (1) or (2) of this Subsection.

C. The provisions of this Section shall not apply when:

(1) The reason for such termination is due to suspension, revocation, or applicable restriction of the health care provider's license to practice in this state by the Louisiana State Board of Medical Examiners, or for another documented reason related to quality of care.

(2) The enrollee or insured chooses to change health care provider.

(3) The enrollee or insured moves out of the geographic service area of the health care provider or health insurance issuer.

(4) The enrollee or insured requires only routine monitoring for a chronic condition but is not in an acute phase of the condition.

D. A health care provider shall be prohibited from discount billing and dual billing pursuant to R.S. 22:250.41 et seq. For purposes of this Section, the treating health care provider shall be deemed to be a contracted health care provider pursuant to R.S. 22:250.41 et seq.

Added by Acts 2004, No. 504, §1, eff. June 25,2004.

§230.7. Flexible health benefit policies, contracts, and agreements

A. For purposes of this Section, notwithstanding any law to the contrary, the following terms shall be defined as follows:

(1) "Flexible health benefits policy, contract, or agreement" means a health insurance policy, contract, or agreement that offers coverage for preventive care, emergency care, inpatient and outpatient hospital care, and physician care but that is not required to include, in whole or in part, state-mandated health benefits.

(2) "Group health policy" is any policy of health and accident insurance covering more than one person. However, for purposes of this Section, "group health policy" shall be limited to any such policy offered to employees of an employer that employs fifty or fewer individuals.

(3) "Health insurance policy, contract, or agreement" means a group health policy or similar coverage issued by a health maintenance organization. For purposes of this Section, such group policies or coverage shall be limited to those offered to employees of employers that employ fifty or fewer individuals. "Health insurance policy, contract, or agreement" shall also mean any individual health policy or health maintenance organization individual subscriber or enrollee agreement.

(4) "Individual health policy" means health insurance coverage offered to an individual in the individual market but does not include limited duration insurance.

(5) "State-mandated health benefits" means coverage required or required to be offered under this Code or other laws of this state to be provided in an individual or group health policy or similar coverage by a health maintenance organization that does any of the following:

(a) Includes coverage for specific health care services or benefits.

(b) Places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts.

(c) Includes a specific category of licensed health care practitioners from which an insured is entitled to receive care.

(d) Requires coverage for all services that a health care practitioner recommends that are consistent with generally accepted principles of professional medicine or a similar standard.

B. A health insurer or health maintenance organization properly authorized in this state may offer one or more flexible health benefits policies, contracts, or agreements. In offering such a policy, contract, or agreement, the health insurer or health maintenance organization shall do each of the following:

(1) Provide written notice to the proposed insured, subscriber, or enrollee, as required in Subsection C of this Section.

(2) Make available to the proposed insured, subscriber, or enrollee, subject to underwriting, at least one health insurance policy, contract, or agreement that provides all state-mandated health benefits.

(3) Provide a list of current state-mandated health benefits to the proposed insured, subscriber, or enrollee.

C. For flexible health benefit policies, contracts, or agreements, the written notice required in Paragraph (B)(1) shall include in bold type within or accompanying the written application for such policy, contract, or agreement the following:

"You have the option to select a flexible health benefits policy, contract, or agreement which is not subject to all of the state-mandated health benefits normally required in insurance policies, contracts, or agreements in this state. You have been provided a list of specific services and benefits mandated to be covered under Louisiana law. This flexible health benefits policy, contract, or agreement may provide a more affordable health insurance policy, contract, or agreement for you. At the same time, it may provide you with fewer health benefits than those normally imposed on health insurance policies, contracts, or agreements in Louisiana. If you are considering this option, please consult with your insurance producer to learn the degree to which the flexible health benefits policy, contract, or agreement does not provide benefits equal to those policies, contracts, or agreements subject to state-mandated health benefits".

Added by Acts 2004, No. 799, §1.

PART VI-A. LOUISIANA HEALTH PLAN

§231. Legislative findings; purpose; short title

A. Existing law does not establish a health coverage program to provide health insurance to Louisiana domiciliaries who are not otherwise able to obtain health insurance meeting prescribed criteria.

B. Uninsurable Louisianians, left to face the cost of major medical care without health coverage, must look to publicly funded programs in the event of severe illness or injury, thereby placing a burden on the resources of the state.

C. Insurance is a business which affects the public interest and which has been subject to regulation in the public interest in this state since 1855; Louisiana's interest in the regulation of insurance is effectuated by the provisions of the Louisiana Insurance Code, R.S. 22:1 et seq., and in other statutes of this state, and is affirmed in the McCarran-Ferguson Act, 15 U.S.C. §1011 et seq.

D. It is the purpose and intent of the legislature to establish a mechanism to insure the availability of health and accident insurance coverage to those citizens of this state who, because of health conditions, cannot secure such coverage.

E. Federal law authorizes the state, subject to federal review and approval, to utilize the Louisiana Health Plan to insure the availability of comprehensive health coverage to those citizens of this state who lose their group health care coverage and are guaranteed access to continuing coverage. Under this authority, the state can provide the plan with the ability to utilize alternate funding sources to reduce rates below two hundred percent of the standard market average cost for similar coverage, provided rates do not fall below one hundred twenty-five percent of the standard market average for similar coverage. Under this authority the financial solvency of the plan for federally defined eligible individuals is guaranteed by fees assessed for plan costs in excess of premiums applicable to participating insurers. It is the purpose and intent of the legislature to establish a mechanism which meets the federal requirements for access to comprehensive health insurance for federally defined eligible individuals and provides options for receipt of alternate funding to improve the affordability of coverage as allowed by federal law.

F. This Part shall be known and may be cited as the "Louisiana Health Plan Act".

G. It is the purpose and intent of the legislature to establish a mechanism to increase the availability of health insurance coverage to small businesses that because of the cost of health insurance are not able to offer such coverage to their employees.

H. REPEALED BY ACTS 2004, No. 493, §2, eff. June 25, 2004.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, Nos. 163, 294, §§1; Acts 2003, No. 528, §1, eff. June 24, 2003; Acts 2004, No. 493, §2, eff. June 25, 2004.

{{**NOTE:** SEE ACTS 1990, NO. 131, §§2 AND 3.}}

§232. Definitions

As used in this Part:

(1) "Ambulatory surgical center" means an establishment in this state as defined in and licensed under the provisions of R.S. 40:2131 et seq., as may be from time to time amended.

(2) "Benefits plan" means the coverages offered by the association to eligible persons as defined by R.S. 22:237.

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

(4) "Church plan" has the meaning given such term under Section 3(33) of the Employee Retirement Income Security Act of 1974.

(5) "Commissioner" means the commissioner of insurance.

(6) "Creditable coverage" means, with respect to an individual, coverage to the individual as defined by R.S. 22:250.1(4).

(7) "Department" means the Department of Insurance.

(8) "Dependent" means a resident spouse or resident unmarried child under the age of twenty-one years, a child who is a student under the age of twenty-four years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.

(9) "Family group insurance" means health and accident insurance as defined in R.S. 22:215(A)(2)(a).

(10) "Federally defined eligible individual" means an individual as defined by R.S. 22:250.12(B).

(11) "Government plan" has the meaning given such term under R.S. 22:250.1(5)(g).

(12) "Group health benefit plan" means an employee welfare benefit plan as defined by R.S. 22:250.1(1).

(13) "Health and accident insurance" means hospital and medical expense incurred policies, nonprofit service plan corporation contracts, and coverages provided by health maintenance organizations, individual practices, associations, the Office of Group Benefits, and other similar entities and self-insurers. The term "health and accident insurance" does not include short term, accident only, hospital indemnity, credit insurance, automobile and homeowner's medical-payment coverage, workers' compensation medical benefit coverage, Medicare, Medicaid, federal governmental benefit plans, supplemental health insurance, limited benefit health insurance, or coverage issued as a supplement to liability insurance.

(14) "Health care provider" means a person licensed by this state to provide health care or professional services under the provisions of Title 37 of the Louisiana Revised Statutes of 1950 or any professional corporation, as a health care provider, authorized to form under the provisions of Title 12 of the Louisiana Revised Statutes of 1950 or such a person licensed by the appropriate laws of another state.

(15) "Health maintenance organization" means an organization as defined in R.S. 22:2002(7).

(16) "Hospital" means any facility as defined in R.S. 40:2102 established for the care and treatment of the sick and injured.

(17) "Insurance arrangement" means any plan, program, contract, or any other arrangement under which one or more natural or juridical persons provide to their employees or participants, whether directly or indirectly, health care services or benefits other than through an insurer. The term shall also include any "self-insurer" as defined herein.

(18) "Insured" means any natural person domiciled in this state, other than a member of the plan, who is eligible to receive benefits from any insurer or insurance arrangement as defined in this Section.

(19) "Insurer" means any insurance company or other entity authorized to transact and transacting health and accident insurance business in this state. Notwithstanding any contrary provisions of R.S. 22:2002(7) or any other law, regulation, or definition contained in this Title, a health maintenance organization shall be deemed an insurer for the purposes of this Part. The term "insurer" shall not include any insurance company whose products are marketed on the home service distribution method and which issues a majority of these policies on a weekly or monthly basis.

(20) "Medical care" means amounts paid for as defined in R.S. 22:250.1(1)(b).

(21) "Medicaid" means coverage provided under the state plan for Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., as amended.

(22) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended.

(23) "Member" means a person covered by the plan.

(24) "Plan" means the Louisiana Health Plan as created in R.S. 22:233.

(25) "Plan of operation" means the plan of operation of the plan, including articles, bylaws, and operating rules, adopted by the board pursuant to R.S. 22:235.

(26) "Private pay patient" means a natural person who is not covered by any policy or plan of insurance or by a self-insurer or whose charges for injury or illness are not compensable by his employer or other insurer or insurance arrangement.

(27) "Public program" means any public assistance program which provides funding for health care services rendered by a health care provider that is directly subsidized by the federal government.

(28) "Self-insurer" means a natural or juridical person which provides health care services or reimbursement for all or any part of the costs of health care for its employees or participants in this state other than through an insurer.

(29) "Small employer" means any person, firm, corporation, partnership, or association actively engaged in business which, on at least fifty percent of its working days during the preceding year, employed not less than one nor more than twenty-five eligible employees. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation shall be considered one employer.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1991, No. 574, §1, eff. July 16, 1991; Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 294, §1; Acts 2001, No. 1178, §2, eff. June 29, 2001; Acts 2005, No. 154, §1, eff. June 28, 2005; Acts 2005, No. 154, §1, eff. June 28, 2005.

§233. Creation of the plan

A. There is hereby created a nonprofit entity to be known as the "Louisiana Health Plan" whose legal domicile shall be in the parish of East Baton Rouge. The plan shall perform its functions under the plan of operation established and approved pursuant to R.S. 22:235 and shall exercise its powers through a board of directors established by R.S. 22:234. For purposes of administration and assessment, the plan shall maintain three accounts:

(1) The state guarantee account for non-federally defined eligible individuals.

(2) The federal guarantee account for federally defined eligible individuals.

(3) The small employer insurance risk account for small businesses that employ at least one but not more than twenty-five employees.

B.(1) The plan is not and may not be deemed a department, unit, agency, instrumentality, commission, or board of the state for any purpose. All debts, claims, obligations, and liabilities of the plan, whenever incurred, shall be the debts, claims, obligations, and liabilities of the plan only and not the state, its agencies, instrumentalities, officers, or employees. The debts, claims, obligations, and liabilities of the plan may not be considered to be a debt of the state or a pledge of its credit.

(2) Notwithstanding the provisions of Paragraph (1) of this Subsection, and except as provided in Paragraphs (3) and (4) of this Subsection, the plan shall be subject to the provisions of R.S. 44:1 et seq. and R.S. 42:4.1 et seq., and may be considered as if it were a public body for the purposes of this Section.

(3) The plan may hold an executive session pursuant to R.S. 42:6 for discussion of one or more of the following, and R.S. 44:1 et seq. shall not apply to any documents as enumerated in R.S. 44:1(A)(2) which relate to one or more of the following:

(a) Names of patients provided to or maintained by the plan, or the administering insurer selected under the provisions of R.S. 22:238.

(b) Matters protected by an attorney-client privilege.

(c) Matters with respect to claims or claims files, except documents contained in those files which are otherwise deemed public records.

(d) Prospective litigation against the plan after formal written demand, prospective litigation by the plan after referral to counsel for review, or pending litigation by or against the plan.

(e) Any other matter now provided for or as may be provided for by the legislature.

(f) Discussion by or documents in the custody or control of any committee or subcommittee of the plan, or any member, employee, or agent, or the board of directors or its members, employees, or agents, provided the discussion or documents would otherwise be protected from disclosure by any of the exceptions provided in this Paragraph.

(4) Any specific fee, procedure, or unit of service pricing information contained in any contract or the form of any contract made, between the plan and any provider of health care services, network of providers of health care services, or managed care plan shall be deemed confidential and shall not be divulged by the plan or the board except that payment may be disclosed and become public record in any legislative, administrative, or judicial proceeding or inquiry. Any information related to payments under a contract or the form of any contract for health care services other than specific fee, procedure, or unit of service pricing shall not be subject to the provisions of this Subsection.

C. The plan and the administering insurer shall be subject to audit by the legislative auditor in accordance with the provisions of R.S. 24:513.

D. There shall be no liability on the part of and no cause of action of any nature shall arise or exist against the plan, its agents or employees, its board of directors, or the commissioner or his representatives for any action taken by them in the performance of their powers and duties under this Part.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 163, §1; Acts 1999, No. 294, §1.

§234. Board of directors

A. The board of directors shall be composed of the commissioner of insurance or his designee, who shall serve as an ex officio, nonvoting member of the board, and twelve members to be selected from the groups and in the manner as follows:

(1) A representative of a domestic insurance company which is a member of the Louisiana Insurers Conference, selected by the conference.

(2) A representative of a foreign insurance company doing business in the state of Louisiana which is a member of the Health Insurance Association of America, selected by the association.

(3) A representative of a domestic nonprofit health service and indemnity plan, selected by the commissioner.

(4) A representative of a health maintenance organization domiciled and doing business in the state of Louisiana, selected by the commissioner.

(5) A representative of the Louisiana Hospital Association, selected by the association.

(6) A representative of the Louisiana State Medical Society, selected by the society.

(7) A representative of the Louisiana Association of Life Underwriters, selected by the association.

(8) The chairman of the Senate Committee on Insurance, or his designee, who shall serve as an ex officio, nonvoting member.

(9) The chairman of the House Committee on Insurance, or his designee, who shall serve as an ex officio, nonvoting member.

(10)(a) Three consumer representatives, selected as follows:

(i) One consumer representative of the Louisiana Health Care Campaign, selected by that organization.

(ii) One consumer representative, selected by the commissioner from a list of persons compiled from recommendations made by any interested group, who at the time of selection is a member of or eligible for membership in the plan.

(iii) One representative of the business community, selected by the commissioner from a list of persons compiled by recommendations by any interested group.

(b) The commissioner shall make all diligent efforts to make selections from these three groups that will represent a racial, ethnic, and gender reflection of the state for the board of directors.

(11) REPEALED BY ACTS 2004, No. 368, §2, eff. June, 23, 2004.

B. Each member of the board other than the commissioner shall serve a term of three years; provided that initially four members shall serve a term of two years and four members shall serve a term of one year, as determined by the board. Members shall serve without compensation but may be reimbursed from the assets of the plan for expenses incurred by them as members of the board of directors.

C. The board shall elect one of its members to serve as chairman for a one year term and may elect such other officers as the board deems necessary to fulfill its duties under this Part, all to serve terms concurrent with that of the chairman.

D. Any vacancy on the board shall be filled for the remaining period of the term in the same manner as the initial appointments were made. The commissioner or the board may fill any vacancy on the board in accordance with the requirements of Subsection A of this Section if the vacancy is not filled within sixty days of its occurrence by the appropriate appointing authority as provided in Subsection A of this Section.

E. The board may make and alter bylaws governing the terms of office of directors, the meetings of the directors, and any other provision not inconsistent with the provisions of this Part.

F. The board shall submit a written report of the operation of the plan to the commissioner and to the Senate Committee on Insurance and House Committee on Insurance by April first of each year.

G-J. REPEALED BY ACTS 1997, No. 1154, §3, eff. Jan. 1, 1998; Acts 1999, No. 163, §1.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1991, No. 574, §1, eff. July 16, 1991; Acts 1992, No. 377, §1, eff. June 17, 1992; Acts 1997, No. 1154, §3, eff. Jan. 1, 1998; Acts 2004, No. 368, §§1 & 2, eff. June 23, 2004.

§235. Plan of operation

A. The board shall submit to the commissioner a plan of operation for the plan and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the plan. The commissioner shall approve the plan of operation provided such is determined to be suitable to assure the fair, reasonable, and equitable administration of the plan.

B. The plan of operation shall become effective upon approval in writing by the commissioner. If the board fails to submit a suitable plan of operation within ninety days after its appointment or at any time thereafter fails to submit suitable amendments to the plan, the commissioner shall adopt and promulgate such reasonable rules and regulations, in accordance with the Louisiana Administrative Procedure Act, as are necessary or advisable to effectuate the provisions of this Section. Such rules and regulations shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner.

C. In its plan of operation the board shall:

(1) Establish procedures for the handling and accounting of assets and monies of the plan.

(2) Establish procedures for the payment of expenses incurred by an administering insurer in the performance of its services.

(3) Establish procedures for the reporting and remittance of charges assessed under R.S. 22:239 to provide for claims paid under the benefits plan and for administrative expenses incurred for the operation of the plan.

(4) Develop and implement a program to publicize the existence of the benefits plan, the eligibility requirements, and procedures for enrollment of members, and to maintain public awareness of the benefits plan.

(5) Establish such other procedures for the operation of the plan to effectuate the purposes of this Part as the board in its discretion deems necessary and proper.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1999, No. 163, §1.

§236. Powers and duties of the plan

The plan shall have the general powers and authority granted under the laws of this state to insurance companies licensed to provide health and accident insurance and, in addition thereto, the specific authority to:

(1) Contract with an outside independent actuarial firm to assess the solvency of the plan and for consultation as to the sufficiency and means of the funding of the plan, and the enrollment in and the eligibility, benefits, and rate structure of the benefits plan to ensure the solvency of the plan.

(2) Close enrollment in benefit plans of non-federally defined eligible individuals at any time upon a determination by the outside independent actuarial firm that funds of the plan are insufficient to support the enrollment of additional non-federally defined eligible individuals.

(3) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Part, including the authority to enter into contracts, with the approval of the commissioner, with similar plans or pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions.

(4) Enter into contracts for the establishment and maintenance of health care cost containment programs as in the discretion of the board are necessary or proper to establish the most cost efficient levels of coverage as provided herein.

(5) Sue or be sued, including taking any legal actions necessary or proper for recovery of any monies due the plan under this Part.

(6) Take such legal action as necessary to avoid the payment of improper claims against the plan or the coverage provided by or through the plan.

(7) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agent's referral fees, and claim reserve formulas, and perform or contract for the performance of any other actuarial function appropriate to the operation of the plan, subject to the following limitations:

(a) Rates for federally defined individuals. (i) Subject to approval by the Department of Insurance, the plan shall determine a standard risk rate for each coverage option offered by considering the premium rates charged by other insurers offering similar health insurance coverage to individuals and family groups. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Subject to the limits provided in this Paragraph, initial rates for each plan year shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein, provided such rates shall not exceed two hundred percent of rates applicable to individual standard risks. Upon the receipt of governmental appropriations or alternative funding sources, other than assessments under R.S. 22:239.1, such as authorized service charges, governmental transfer payments, donations or grants, the board shall be authorized to reduce rates for the plan year based on established actuarial and underwriting practices. In no event shall rates for plan coverage be less than the greater of one hundred twenty-five percent of rates established as applicable for individual standard risks or rates established for other individuals provided coverage by or through the plan unless such rates would exceed the maximum amount allowed under this Paragraph. In no instance shall the rates discriminate between covered individuals on the basis of health-related factors.

(ii) Notwithstanding any other provision of this Part to the contrary, for persons eligible under a federal waiver pursuant to R.S. 22:237(B)(2), the board may authorize a premium subsidy if such a premium subsidy is authorized by the federal waiver. If the board authorizes a premium subsidy, the total amount of the subsidy may not be more than sixty-six percent of the premium otherwise specified by this Part. The board may authorize the Louisiana Health Plan to provide for the non-federal share of such premium subsidy. Nothing herein shall permit rates to be calculated other than as described in this Part, or otherwise restrict the board from participating in other components of the federal waiver.

(b) Rates for other individuals. (i) Rates shall not be unreasonable in relation to the coverage provided, the risk experience, and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim cost and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices. In no instance shall the rates discriminate between covered individuals on the basis of health-related factors.

(ii) Notwithstanding any other provision of this Part to the contrary, for persons eligible under a federal waiver pursuant to R.S. 22:237(D)(2), the board may authorize a premium subsidy if such a premium subsidy is authorized by the federal waiver. If the board authorizes a premium subsidy, the total amount of the subsidy may not be more than sixty-six percent of the premium otherwise specified by this Part. The board may authorize the Louisiana Health Plan to provide for the non-federal share of such premium subsidy. Nothing herein shall permit rates to be calculated other than as described in this Part, or otherwise restrict the board from participating in other components of the federal waiver.

(c) Policy fees or other compensation, or consideration paid to agents. No agent's fees or other compensation, or consideration shall be payable for coverage offered through the plan unless:

(i) The agent is duly registered and certified by the plan under a plan approved by the commissioner of insurance.

(ii) The agent certifies in writing that to the best of his knowledge the individual is a qualifying individual as defined by R.S. 22:237 or 250.12(B).

(iii) The agent has entered into a participation agreement with the plan which provides for recoupment of amounts paid for certifications found to be erroneous.

(d) Reimbursement of expenses. The board shall be authorized to establish policy fees or other compensation, or consideration for reimbursement of the reasonable expenses of participating agents. The plan shall be authorized to recoup any amounts paid for an agent certification found to be erroneous or improper.

(8) Issue individual and family group policies of insurance in accordance with the requirements of this Part.

(9) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the plan, policy and other contract design, and any other function within the authority of the plan.

(10) Repealed by Acts 2004, No. 493, §2, eff. June 25, 2004.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 163, §1; Acts 2003, No. 528, §1, eff. June 24, 2003; Acts 2004, No. 493, §2, eff. June 25, 2004; Acts 2005, No. 154, §1, eff. June 28, 2005.

§237. Eligibility

A. Any natural person who has been domiciled in this state for six consecutive months shall be eligible for coverage as a nonfederally defined individual as provided in this Part, except the following:

(1) Any person who, on the effective date of coverage by the plan or at any time thereafter, is eligible for coverage under health and accident insurance offered by an insurer, reinsurer, or insurance arrangement. A person shall be considered eligible for coverage by an insurer or insurance arrangement as described herein if he meets the criteria for eligibility under any group health benefits plan provided by his employer, union, or other organization of which he is a member, whether or not the person actually is covered under such plan.

(2) Any person who is, at the time of application for coverage by the plan, eligible for health benefits under Medicaid or Medicare as defined in R.S. 22:232.

(3) Any person whose coverage by the plan was terminated for nonpayment of premiums unless twelve months have lapsed since such termination.

(4) Any person on whose behalf the plan has paid out the maximum lifetime benefits under the benefits plan as may be established by the plan.

(5) Inmates of public institutions.

(6) Persons eligible for public programs as defined in R.S. 22:232.

(7) Persons who are not domiciled in this state.

B.(1) Any federally defined eligible individual who is and continues to be a resident of this state shall be eligible for plan coverage as an individual or family group. Each dependent of a person who is eligible for plan coverage shall also be eligible for plan coverage under the family group.

(2) Any person meeting any and all eligibility requirements under any approved federal waiver shall be eligible for plan coverage, provided all other eligibility criteria for plan coverage as a federally defined eligible individual are met.

C. Any person who ceases to meet the eligibility requirements of this Section may be terminated from coverage by the plan at the time of renewal but any unearned premium shall be refunded. However, this Subsection shall not apply to any person receiving cancer treatment or cancer therapy or any person with an immune system disorder requiring immuno-suppression drug treatment or maintenance not covered by Medicaid or Medicare unless such person is eligible for or has attained Medicare at age sixty-five or older.

D.(1) Nonfederally defined eligible individuals whose health and accident insurance coverage has been involuntarily terminated may apply for coverage under the plan. If such coverage is applied for within sixty-three days after the involuntary termination and if premiums assessed by the plan are paid for the entire coverage period, the effective date of the coverage by the plan shall be the date of termination of the previous coverage.

(2) Any person meeting any and all eligibility requirements under any approved federal waiver shall be eligible for plan coverage, provided all other eligibility criteria for plan coverage as a nonfederally defined eligible individual are met.

E. Any natural person who changes his domicile to this state and who at the time domicile is established in this state is insured by the health insurance plan or similar organization for his former domiciliary state shall be eligible for coverage by the plan if:

(1) The health insurance plan or similar organization of the former domiciliary state provides coverage similar to that offered by the plan.

(2) The health insurance plan or similar organization of the former domiciliary state certifies, on a form acceptable to the plan, that the person seeking coverage by the plan is currently insured in such other state.

(3) The commissioner determines that the law of the former domiciliary state provides similar coverage to Louisianians insured by the plan upon their establishment of domicile in such other state.

F.(1) Notwithstanding the provisions of Paragraph A(1) of this Section, upon certification by an independent actuarial firm that funds of the plan are sufficient to support the enrollment of additional persons, the board may authorize the enrollment of additional persons as provided for in this Subsection. Any person whose individual insurance premium rate for comparable coverage exceeds by more than two hundred percent the maximum rate which the plan may be authorized to charge under R.S. 22:240(F)(3), for persons of comparable age, sex, and geographical location, shall be eligible for coverage as provided in this Part.

(2) As used in this Subsection, the term "eligible" shall not include persons whose employer, union, or other organization provides a group health benefits plan through an insurer or insurance arrangement to its employees or members, or their dependents, and such person is eligible for coverage under such group health benefits plan.

(3) Plan coverage for which a person is eligible under this Subsection shall exclude charges or expenses incurred or caused by preexisting conditions, as provided in R.S. 22:240(G).

(4) The board shall establish policies and procedures to effectuate the provisions of this Subsection, which policies and procedures shall:

(a) Guarantee uninterrupted enrollment of federally defined eligible individuals.

(b) Give preference to the applications for membership of persons who, at the time of application, are uninsured and uninsurable, and satisfy the eligibility requirements of Subsection A of this Section.

(5)(a) It shall constitute an unfair trade practice under the provisions of R.S. 22:1211 et seq., for any insurer, reinsurer, insurance agent or broker, or employer, to refer an individual employee to the plan, or to arrange for an individual employee to apply to the program, for the purpose of separating such employee from a group health benefits plan provided in connection with the employee's employment.

(b) In the event that an individual receives coverage by the plan in contravention of this Subsection, the plan may terminate the coverage of the individual but shall maintain a cause of action against any offender of this Subsection for a total amount not less than double the amount of any or all claims paid on behalf of the individual whenever made, without limitation, plus ten thousand dollars for each incident, and attorney fees, court costs, and interest from date of demand by the plan.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1991, No. 574, §1, eff. July 16, 1991; Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 163, §1; Acts 2001, No. 65, §1, eff. May 24, 2001; Acts 2004, No. 368, §1, eff. June 23, 2004.

§238. Administering insurer

A. The board shall select an administrator or administrators, which may consist of an insurer or insurers, a third-party administrator or administrators, medical or pharmaceutical providers, or a combination thereof, through a competitive bidding process to administer the benefits plan of the plan. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(1) The administrator's proven ability to handle individual health and accident insurance.

(2) The efficiency of the administrator's claim payment procedures.

(3) An estimate of total charges for administering the benefits plan.

(4) The administrator's ability to administer the benefits plan in a cost-efficient manner.

B.(1) The commissioner shall appoint the administrator or administrators if the administrator or administrators have not been selected within sixty days of the appointment of the board.

(2) The administrator or administrators shall serve for a period of three years, subject to removal for cause.

(3) At least six months prior to the expiration of each three-year period of service by an administrator, the board shall invite all administrators, including the current administering administrator or administrators, to submit bids to serve as an administrator for the succeeding three-year period. Selection of an administrator for the succeeding period shall be made at least three months prior to the end of the current three-year period. Nothing in this Section shall prohibit a competitive bid process prior to the three-year period in the event of termination of an administrator or administrators.

C.(1) The administrator shall perform all eligibility and administrative claims payment functions relating to the plan.

(2) The administrator shall establish a premium billing procedure for collection of premiums from persons insured by the plan. Billings shall be made on a periodic basis as determined by the board.

(3) The administrator shall perform all necessary functions to assure timely payment of benefits to persons insured by the plan, including:

(a) Making available information relating to the proper manner of submitting a claim for benefits to the plan and distributing forms upon which submission shall be made.

(b) Evaluation of the eligibility of each claim for payment by the plan.

(4) The administrator shall submit regular reports to the board regarding the operation of the plan. The frequency, content, and form of the report shall be determined by the board.

(5) Following the close of each calendar year, the administrator and actuarial consultants shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year, and report this information to the board.

(6) The administrator shall be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1999, No. 163, §1; Acts 2004, No. 368, §1, eff. June 23, 2004.

§239. Service charges

A.(1) Each patient, except a private pay patient, one covered by Medicare or any other public program, one who is covered by the State Employees Group Benefit Program, or one covered by an insolvent insurer, admitted to a hospital for treatment other than psychiatric care or alcohol or substance abuse, shall be assessed a service charge of two dollars for each day, or portion thereof, during which the patient is confined as an inpatient in that facility.

(2) Each hospital in which a patient is confined shall calculate the total service charge due for that patient's period of confinement and shall include the total service charge in the bill for services rendered to the patient. The individual patient may be obligated to pay the service charge assessed in the event that an insurance arrangement pays for any medical charges or benefits but fails to pay the service charge assessed pursuant to this Section. The service charge shall be collected as provided for in the plan of operation of the plan as established pursuant to R.S. 22:235.

(3) For purposes of this Section only, "hospital" shall not include any hospital operated by the state, or any hospital created or operated by the Department of Veterans Affairs or other agency of the United States of America or any facility operated solely to provide psychiatric care or treatment of alcohol or substance abuse, or both.

B. Each patient, except a private pay patient, one covered by Medicare or any other public program which is directly subsidized by the federal government, one who is covered by the State Employees Group Benefit Program, or one covered by an insolvent insurer, admitted to an ambulatory surgical center or to a hospital for outpatient ambulatory surgical care shall be assessed a service charge of one dollar for each admission to that facility. The service charge shall be included in the bill for services or supplies, or both, rendered to the patient by the ambulatory surgical center or hospital.

C.(1) Each hospital and ambulatory surgical center shall bill for and collect the service charges assessed herein from monies remitted to it in payment thereof in accordance with R.S. 22:213.2, if authorized by the plan of operation under R.S. 22:235. In the event that no payment is made by or on behalf of the patient for services rendered, the health care provider shall be liable only for the remittance of those fees collected. Each hospital and ambulatory surgical center shall remit to the plan for each reporting period, as established in the plan of operation, the total amount of service charges collected during that reporting period in accordance with the reporting and remittance procedures established by the plan pursuant to R.S. 22:235.

(2) Unless permitted by the board, the intentional failure to bill, pay, report, or delineate as service charges in accordance with this Section shall cause the hospital or ambulatory surgical center to be liable to the plan for an amount determined by the board, not to exceed five hundred dollars, plus interest, per failure. Any hospital or ambulatory surgical center found to have intentionally failed to bill, pay, report, or delineate as service charges according to this Section unless permitted by the board on three or more occasions during a six-month period shall be liable for an amount determined by the board, not to exceed one thousand five hundred dollars per failure, together with attorney fees, and court costs.

(3) The plan or the commissioner, or both, are specifically authorized and empowered to conduct audits of hospitals and ambulatory surgical centers in order to enforce compliance with this Section. Fines levied under this Section shall be consistent with those levied against insurers under this Part.

D. The service charges imposed on hospital and ambulatory surgical center patients by this Section shall be payable by the patient's insurer or insurance arrangement, if any, as applicable, except such charges shall not be payable by an insolvent insurer. In no event shall a hospital or ambulatory surgical center be required to remit to the plan uncollected service charges for any patient who is a private pay patient or for any patient whose insurer or insurance arrangement is not legally required to pay the service charge.

E. If monies in the plan at the end of any fiscal year exceed actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the board to offset future losses. As used in this Subsection, "future losses" includes reserves for incurred but not reported claims.

F. For the purposes of this Section, insurance, insurance arrangement, or policy of an insurer also includes any policy or plan of insurance or of self-insurance which provides payment, indemnity, or reimbursement for charges resulting from accident, injury, or illness when an employer or insurer is responsible for those charges. The terms insurance, insurance arrangement, or policy shall not include short-term, accident only, fixed indemnity, credit insurance, automobile and homeowner's medical payment coverage, or coverage issued as a supplement to liability insurance.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1991, No. 768, §1, eff. July 19, 1991; Acts 1993, No. 191, §1; Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 163, §1.

§239.1. Fees assessed to participating health insurers for plan losses attributable to federally defined eligible individuals

A.(1) For the purposes of this Section, "participating insurer" includes all insurers providing health insurance to citizens of this state.

(2) For the purposes of this Section, fees assessed to participating insurers shall apply to gross premiums for hospital and medical expense incurred policies, nonprofit service plan corporation contracts, hospital only coverage, medical and surgical expense policies, major medical insurance, coverages provided by health maintenance organizations, individual practices, associations, and every insurance appertaining to any portion of medical expense liability incurred under a group health plan, as defined in R.S. 22:250.1(1)(a), including stop-loss and excess-loss coverage unless the gross premium for such coverage is included under any other type of coverage stated herein that is issued for delivery in this state. Fee assessments to participating insurers shall not apply to policies or contracts for provision of short term, accident only, hospital indemnity, credit insurance, automobile and homeowner's medical-payment coverage, workers' compensation medical benefit coverage, Medicare, Medicaid, federal governmental benefit plans, supplemental health insurance, limited benefit health insurance, or coverage issued as a supplement to liability.

B. In addition to the powers enumerated in R.S. 22:236, the plan shall have the authority to assess fees to participating insurers in accordance with the provisions of this Section, and to make advance interim fee assessments as may be reasonable and necessary for the plan's organizational and interim operating expenses. Any such interim fees assessed are to be credited as offsets against any regular fees assessed which become payable following the close of the fiscal year.

C. Following the close of each fiscal year, the administrator shall determine the net premiums, premiums less reasonable administrative expense allowances, the plan expenses of administration, and the incurred losses for the year which are attributable to federally defined eligible individuals. The administrator shall take into account investment income and other appropriate gains and losses which are reasonably attributable to federally defined eligible individuals. Any deficit incurred by the plan shall be identified and recouped as follows:

(1) The board shall identify the source of any deficit related to the provision of coverage to federally defined eligible individuals before assessing any fees authorized under this Section.

(2) The board shall verify the adequacy of any governmental appropriations or alternative funding sources, other than fees assessed under this Subsection, used to reduce rates for the plan year below two hundred percent of rates applicable to individual standard risks. Where such funds were not sufficient to support the rate reduction provided, that portion of the deficit reasonably related to such funding shortfalls shall be recouped from any subsequent governmental appropriations or alternative funding sources, other than fees assessed under this Section, prior to making any rate reduction for a subsequent plan year. The board shall reasonably act to prevent future deficits related to reducing rates based on receipt of government appropriations or alternate funding sources.

(3) The board shall verify the amount of any deficit reasonably resulting from plan losses not attributable to governmental or alternative funding shortfalls used to reduce rates below two hundred percent of rates applicable to individual standard risks. Any verified deficit amount attributed to federally defined eligible individuals shall be recouped by fees assessed under this Section to participating insurers.

(4) The board shall provide the commissioner of insurance with a detailed report on any deficit being recouped by fee assessments apportioned under this Section. Such report shall include information on services and utilization patterns which can reasonably be attributed to the deficit as well as analysis and recommendations on cost containment measures which can be taken to minimize future deficits.

(5) The board shall provide the commissioner of insurance with a detailed report on the sources and use of government appropriations and alternate sources of funding used to make rates more affordable. Such report shall include information on the activities of similar plans maintained by other states and recommendations for actions which can be taken to make coverage more affordable for plan members.

D. Each participating insurer's fee assessment shall be in the proportion to gross premiums earned on business in this state for policies or contracts covered under this Section for the most recent calendar year for which information is available.

E. Each participating insurer's fee assessment shall be determined by the board based on annual statements and other reports deemed to be necessary by the board and filed by the participating insurer with the board. The board may use any reasonable method of estimating the amount of gross premium of a participating insurer if the specific amount is unknown.

F. A participating insurer may petition the commissioner of insurance for deferral of all or part of any fee assessed by the board. If, in the opinion of the commissioner, payment of the fee assessment would endanger the solvency of the participating insurer, the commissioner may defer, in whole or in part, the fee assessment as part of a voluntary rehabilitation or supervisory plan established to prevent the plan's insolvency. Any deferrals approved under a voluntary rehabilitation or supervisory plan shall be limited to four years and require repayment of all deferrals by the end of such period plus legal interest. Until notice of payment in full is received from the board, the insurer shall remain under the voluntary rehabilitation or supervisory plan. In the event a fee assessment against a participating insurer is deferred in whole or in part, the amount by which the fee assessment is deferred may be assessed to the other participating insurers in a manner consistent with the basis for fee assessments set forth in this Section. Collection of such deferrals and legal interest shall be used to offset fee assessments against the other participating insurers in a manner consistent with the basis for fee assessments set forth in this Section.

Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 2001, No. 62, §1, eff. May 24, 2001; Acts 2001, No. 1178, §2, eff. June 29, 2001.

§239.2. Powers and duties of the commissioner

A. In addition to the duties and powers enumerated elsewhere in this Part, and in other provisions of law, the commissioner shall upon request of the board of directors, and notwithstanding any provision of law to the contrary, provide the plan with a statement of the premiums, in this and other appropriate states, for each participating insurer.

B. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any participating insurer who fails to pay assessed fees when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on any participating insurer who fails to pay an assessed fee when due. The fine shall not exceed five percent of the unpaid fee assessment per month, but no fine shall be less than one hundred dollars per month.

Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 163, §1.

§239.3. Miscellaneous provisions

A. Nothing in this Part shall be construed to reduce or offset the liability for unpaid fees assessed to an impaired or insolvent insurer operating a plan with liability for fees assessed under this Part.

B. For purposes of carrying out its obligations under this Part, the plan shall be deemed to be a creditor of an impaired or insolvent participating insurer to the extent of assets attributable to covered policies reduced by any amounts to which the plan is entitled for unpaid fees assessed. As provided for under R.S. 22:1395.13, payment of contractual obligations of an impaired or insolvent insurer shall include fees assessed under this Part.

C. Any unpaid fees assessed to a participating insurer shall become the liability of any continuing or successor insurer.

Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 163, §1.

§240. Benefits; availability

A. The plan shall offer comprehensive coverage to every eligible person who is not eligible for Medicare and public programs as defined in this Part. Comprehensive coverage offered by the plan shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under Paragraph (4) of Subsection F of this Section, up to a maximum lifetime benefit as established by the board of not less than five hundred thousand dollars per covered person, payable up to a maximum of one hundred thousand dollars per covered person per twelve consecutive months of coverage. For federally defined eligible persons, the board shall establish benefits and maximum benefit amounts in accordance with applicable federal law and regulations.

B. The board shall establish reasonable reimbursement amounts for the following services and articles prescribed by a health care provider and determined by the plan to be medically necessary, including but not limited to:

(1) Hospital services.

(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions which are rendered by a health care provider or by other licensed professionals at the direction of a health care provider.

(3) Services of a licensed skilled nursing facility for up to a maximum of one hundred twenty days per twelve consecutive months of coverage, unless extended for additional days under any cost containment program implemented by the board pursuant to Subsection I of this Section.

(4) Services of a home health agency up to a maximum of two hundred seventy services per twelve consecutive months of coverage, unless increased under any cost containment program implemented by the board pursuant to Subsection I of this Section.

(5) Use of radium or other radioactive materials.

(6) Oxygen.

(7) Anesthetics.

(8) Prostheses other than dental.

(9) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the conditions for which it is prescribed.

(10) Diagnostic X-rays and laboratory tests.

(11) Oral surgery for excision of partially or completely unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of other teeth.

(12) Services of a physical therapist.

(13) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition.

C. The board shall establish reasonable reimbursement amounts for any services covered under the benefits plans which are not included in Subsection B of this Section.

D. In the event the amounts charged for services and articles provided by or at the direction of a health care provider exceed the amount payable for covered expenses as provided herein, the health care provider may seek payment of the balance owed from the member as allowed under applicable contracts or state and federal laws and regulations.

E. Covered expenses shall not include the following, except as mandated by applicable federal law for federally defined eligible individuals:

(1) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions.

(2) Care which is primarily for custodial purposes.

(3) Any charge for confinement in a private room to the extent surcharge is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician.

(4) That part of any charge for services rendered or articles prescribed by a physician, dentist, or other health care provider which exceeds the reasonable reimbursement amounts established in Subsections B and C of this Section or for any charge not medically necessary.

(5) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles.

(6) Any expense incurred prior to the effective date of coverage by the plan for the person on whose behalf the expense is incurred.

(7) Dental care except as provided in Subsection B of this Section.

(8) Eyeglasses and hearing aids.

(9) Illness or injury due to acts of war.

(10) Services of blood donors and any fee for failure to replace the first three pints of blood provided to an eligible person each policy year.

(11) Personal supplies or personal services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.

(12) Any charge for the diagnosis and treatment of mental and nervous disorders, including alcohol and substance abuse.

F.(1) Premiums charged for coverages issued by the plan may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage.

(2) Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks. Separate schedules of premium rates for federally defined eligible individuals may be based on age, sex, and geographical location, in accordance with applicable federal laws and regulations.

(3) The plan shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the state comparable to the plan coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Standard risk rates for federally defined eligibles shall comply with all applicable federal laws and regulations. Initial rates for plan coverage provided to non-federally defined eligible individuals shall not be less than one hundred fifty percent of rates established as applicable for individual standard risks, or the minimum monthly rates as provided for herein, whichever is greater. Subsequent rates provided to non-federally defined eligible individuals shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall plan rates exceed two hundred percent of rates applicable to individual standard risks.

(4) The plan coverage defined in this Section shall provide benefits, deductibles, coinsurance, and copayments to be established by the board. In addition, the board may establish optional benefits, deductibles, coinsurance, and copayments.

G. Plan coverage provided to non-federally defined eligible individuals shall exclude charges or expenses incurred for or caused by preexisting conditions as allowed under R.S. 22:250.12(A)(1)(b).

H.(1) Notwithstanding any other law to the contrary, the coverage provided by the plan shall be considered excess coverage, and benefits otherwise payable under plan coverage shall be reduced by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable by any insurer or insurance arrangement or any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(2) The plan shall have a cause of action against an eligible person for the recovery of the amount of benefits paid by it which are not covered expenses. Benefits due from the plan may be reduced or refused as a set-off against any amount recoverable under this Paragraph.

I. The benefits plan offered pursuant to this Section shall include such managed care provisions as the board deems necessary and proper for:

(1) Compliance with applicable federal laws and regulations regarding choices of benefit coverage for federally defined eligible individuals.

(2) Containment of costs, including precertification and concurrent or continued stay review of hospital admissions, mandatory outpatient surgical procedures, preadmission testing, or any other provisions determined by the board to be cost effective and consistent with the purposes of this Part.

J. Except as otherwise provided in this Part and in R.S. 22:213.2, this Section shall establish the exclusive means for determining the benefits required to be offered by the plan, notwithstanding any mandatory benefits or required policy provisions in this Title to the contrary.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1992, No. 283, §1, eff. June 11, 1992; Acts 1992, No. 955, §1, eff. July 9, 1992; Acts 1997, No. 1154, §1, eff. Jan. 1, 1998; Acts 1999, No. 163, §1; Acts 2004, No. 368, §1, eff. June 23, 2004.

§241. Mandated benefits

Service charges assessed to any patient pursuant to R.S. 22:239 shall be a mandated benefit of any insurance policy, insurance certificate, insurance arrangement or self-insurance which provides coverage to such patient, except that such charges shall not be payable by any insurer which is insolvent.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990.

§242. Exemptions; relation to other laws

A. The plan established pursuant to this Part shall be exempt from any and all state and local taxes.

B. The plan and any insurer selected by the board to administer the benefits plan shall be exempt from the provisions of R.S. 22:657.

Acts 1990, No. 131, §1, eff. Sept. 1, 1990; Acts 1999, No. 163, §1.

PART VI-B. LOUISIANA BASIC HEALTH INSURANCE PILOT PROGRAMS

§244. Louisiana Basic Health Insurance; title

This Part shall be known and may be cited as the "Louisiana Basic Health Insurance", and any program created under R.S. 22:246 shall be referred to as LaChoice.

Acts 1993, No. 660, §1; Acts 1999, No. 294, §1; Acts 2004, No. 751, §1.

§245. Authorization to develop pilot programs

A. The Department of Insurance is authorized to establish pilot health insurance programs to increase access to affordable health insurance for small employers and for individuals. In conjunction with the Department of Health and Hospitals and after consultation with the Louisiana Health Care Commission, the department is authorized to develop private health insurance coverage for small employers and individuals, as further provided in R.S. 22:246 and R.S. 22:246.1.

B. In conjunction with the Louisiana Business Group on Health and the Louisiana Health Care Commission, the department is hereby authorized to establish employer purchasing cooperatives and other pilot programs that increase access to affordable group and individual health insurance coverage that meets the minimum requirements of Part VI-C of this Chapter, as further provided in R.S. 22:247.

C. For the purpose of making health insurance coverage available to individuals who lose coverage as a result of their employer going out of business and terminating a health benefits plan and who are eligible for the Health Coverage Tax Credit under federal law, the Department of Insurance shall administer the federal Health Coverage Tax Credit program to ensure access of affordable health insurance for eligible individuals. To accomplish such purpose the department:

(1) Shall establish a pilot program to increase access to affordable health insurance for eligible individuals under the federal Health Coverage Tax Credit program.

(2) Shall coordinate with health insurance issuers, health maintenance organizations, employers, or other entities to facilitate insurance coverage for eligible individuals.

(3) The commissioner may, after notice and hearing, promulgate such rules and regulations as may be necessary or proper to carry out the provisions of this Part and the provisions of R.S. 22:231 through 242. Such rules and regulations shall be promulgated and adopted in accordance with the Administrative Procedures Act.

Acts 1993, No. 660, §1; Acts 1997, No. 974, §1; Acts 1999, No. 294, §1; Acts 2003, No. 424, §1, eff. June 18 2003; Acts 2004, No. 751, §1; Acts 2004, No. 843, §1.

§246. Small employer and individual insurance program criteria

Any small employer or individual insurance program developed shall include but not be limited to the following features:

(1) Eligibility criteria for small employers that may include limiting participation to those employers who have not offered group health insurance coverage to their employees for at least two years or such shorter period as may be permitted by regulation promulgated by the commissioner of insurance. Any pilot program involving a public subsidy towards the purchase of policies or contracts of coverage will have additional eligibility criteria established by the Department of Health and Hospitals for participation of health insurance issuers.

(2) Eligibility criteria that limit participation to health insurance issuers who have not been found to be financially impaired by the department in the preceding two years. For purposes of this Section, the term "health insurance issuer" shall mean an insurance company, including a health maintenance organization as defined and licensed pursuant to Part XII of Chapter 2 of this Title.

(3) Participation criteria that limits the number of policies or contracts of coverage that a participating health insurance issuer may issue under the program to twenty percent of the health insurance issuer's other commercial coverage that meets the requirements of Part VI-C of this Chapter.

(4) Benefit criteria that require participating health insurance issuers to offer group and individual health insurance as defined in R.S. 22:250.1(2).

(5) Health insurance criteria for health insurers that define the coverage that may be marketed under the program. Notwithstanding any law to the contrary, small employer group insurance approved for marketing under the program shall be required to meet the requirements of Part VI-C of this Chapter.

(6) Underwriting criteria that establish standards for normal insurance risk associated with individuals covered under a pilot program. Such criteria shall include underwriting standards based on each health insurance issuer's group and individual insurance products approved for marketing under a pilot program.

(7) Risk criteria for payment of losses resulting from individuals whose medical conditions do not meet the standards for normal group or individual insurance risk established pursuant to Paragraph (6) of this Section. The risk criteria established shall utilize medical loss data, compendium data, or an actuarial certification of the loss determination method by an actuary certified by the American Academy of Actuaries in Health Insurance.

(8) Employer participation requirements that provide for payment of at least fifty percent of the eligible employee premium cost or twenty-five percent of the premium cost for all persons covered under the group benefit plan.

(9) Participation requirements that may provide for a minimum number of eligible employees to be covered by the plan. Such requirements shall not require participation of more than seventy-five percent of all eligible employees or sixty percent of those eligible employees who do not have other creditable coverage or fifty percent of those eligible employees who do not have creditable coverage with carriers other than the participating carrier.

(10) Criteria for providing a public subsidy towards the purchase of policies or contracts of coverage.

(11) Provider payment requirements for participating health insurers.

Acts 1993, No. 660, §1; Acts 1995, No. 593, §1; Acts 1997, No. 974, §1; Acts 1999, No. 294, §1; Acts 2003, No. 424, §1, eff. June 18, 2003; Acts 2004, No. 751, §1.

§246.1. Blanket insurance program; criteria by Department of Health and Hospitals; exemptions

A. Any blanket insurance program developed by the Department of Health and Hospitals shall include but not be limited to the following components:

(1) The eligibility criteria for individuals, including limiting participation to a specific number of individuals who are eligible for medical assistance pursuant to a coverage program implemented pursuant to approval of the secretary of the United States Department of Health and Human Services using authority granted under Section 1115 of the Social Security Act.

(2) The eligibility criteria for health insurance issuers that limit participation to health insurance issuers who have not been found to be financially impaired by the Department of Insurance in the preceding two years and have been selected by the Department of Health and Hospitals. For purposes of this Section, the term "health insurance issuer" shall mean an insurance company, including a health maintenance organization as defined and licensed pursuant to Part XII of Chapter 2 of this Title.

(3) The participation criteria that may limit the number of policies or contracts of coverage that a participating health insurance issuer may issue under the program to twenty percent of the health insurance issuer's other commercial coverage that satisfies the requirements of Part VI-C of this Chapter.

(4) The health insurance criteria for health insurers that define the coverage that may be provided under the program. The mandatory benefits or mandatory benefit options, including the provision of "basic health care services" by health maintenance organizations, shall not be required to be included in the program created by this Section.

(5) The payment methodology for participating health insurers.

(6) The provider payment requirements for participating health insurers.

B. In addition to the exemptions provided in Subsection A of this Section, R.S. 22:215(D) and (E), 218, and 250.36 shall not apply to any Department of Health and Hospitals blanket insurance program.

Added by Acts 2004, No. 751, §1.

§247. Employer group health insurance purchasing cooperative plan

A. For purposes of this Section, a purchasing cooperative shall be treated as a bona fide association as defined in R.S. 22:250.1(5)(b). Employers participating in a purchasing cooperative shall meet the same participation requirements required of an employer association under this Title. A purchasing cooperative shall be authorized to establish minimum health insurance issuer participation rates for employers who participate in the purchasing cooperative.

B.(1) The purchasing cooperative shall file for approval by the department any plan for spreading risk across health insurance issuers who participate in such cooperative. The department shall determine whether such risk spreading mechanisms are actuarially sound and include appropriate safeguards to assure fidelity of any funds used for such purposes.

(2) No asset or funds used for spreading risk across health insurance issuers shall be encumbered, pledged, or utilized to secure a loan or to confer a personal benefit on any officer, director, employee, agent, stockholder, or any beneficiary of any trust of any other person responsible to the purchasing cooperative.

(3) Any person and any officer, director, employee, agent, partner, stockholder, or any beneficiary of any trust in violation of this Subsection shall be fined two times the amount of the benefit conferred but not less than ten thousand dollars and shall be removed forthwith from any office, position, capacity, or relationship with the purchasing cooperative. In such instances, the commissioner shall have a cause of action and standing to sue to recover and conserve such property.

C. Any purchasing cooperative developed shall include choices and options in coverage and benefits. Any such purchasing cooperative shall also provide employers and employees with data that includes but is not limited to cost, quality, and outcomes of care offered by the various health care insurers and managed care organizations participating in the plan.

Acts 1993, No. 660, §1; Acts 1997, No. 974, §1; Acts 1999, No. 294, §1.

§248. Regulations

The commissioner of insurance shall, in accordance with the Administrative Procedure Act, adopt rules and regulations to establish each basic benefit health insurance pilot that may be developed. Such rules and regulations shall include specific standards for benefits, performance criteria for claim payments, marketing practices, and compliance requirements of state law for group and individual health insurance coverage.

Acts 1999, No. 294, §1.

§249. Community-based health care access programs

A.(1) A program operating in this state that is, or has been supported by grant funds from the Healthy Communities Access Program Grant from the United States Department of Health and Human Services, may establish a pilot program to coordinate health care provider reimbursements in order to test innovations in payment for health care services.

(2) A pilot program established under Paragraph (1) of this Subsection shall meet the requirements of this Section.

B.(1) A pilot program established under this Section:

(a) May enroll participants who have not purchased insurance in at least twelve months and whose income is at or below three hundred percent of the federal poverty level.

(b) Is limited to employees of employers who have not offered commercial health insurance for a period of time to be established by each pilot program, but to be no less than the previous twelve months and who are not covered or eligible for other reimbursement programs, such as the Louisiana Children's Health Insurance Plan, Medicaid, or Medicare Program.

(c) Shall drop any employer found falsifying information or dumping existing commercial health insurance coverage.

(d) Shall coordinate payment from enrollees, and employers of enrollees, to be used to obtain available funding to assist in providing reimbursements to health care providers of enrollees.

(e) Shall enter into agreements with health care providers to coordinate and provide services to enrollees.

(2) Agreements that are entered into under Subparagraph (1)(e) of this Subsection are contingent on the health care provider agreeing to the provision of payment by the pilot program based on available funding to the pilot program for the health care services being provided.

C. A pilot program established under this Section:

(1) Shall be considered as a non-insurance program.

(2) Is not subject to insurance laws or regulation by the Commissioner of Insurance.

D. A pilot program established pursuant to this Section shall be administered by a nonprofit corporation duly incorporated in the state of Louisiana.

E. A pilot program established under this Section shall issue a report to the state which shall include the following:

(1) An analysis of the financial status of the pilot.

(2) Data on enrollees and providers.

(3) A description of enrollee services utilized.

(4) Other information as requested by the committees.

Added by Acts 2004, No. 593, §1.

PART VI-C. ASSURING PORTABILITY, AVAILABILITY, AND RENEWABILITY OF HEALTH INSURANCE COVERAGE

§250. [Blank]
§250.1. Definitions

As used in Part IV-C of this Chapter, the following terms shall have the following meanings:

(1)(a) "Group health plan" means an employee welfare benefit plan (as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care, as defined in Subparagraph (b), and including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

(b) "Medical care" means amounts paid for:

(i) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body.

(ii) Amounts paid for transportation primarily for and essential to medical care referred to in Item (i) of this Subparagraph.

(iii) Amounts paid for insurance covering medical care referred to in Items (i) and (ii) of this Subparagraph.

(c) A program under which creditable coverage described in Paragraph (4) of this Section is provided shall be treated as a group health plan for purposes of applying R.S. 22:250.2(E).

(2) Definitions relating to health insurance are:

(a) "Health insurance coverage" means benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization, or health maintenance organization contract offered by a health insurance issuer.

(b) "Health insurance issuer" means an insurance company, including a health maintenance organization, as defined and licensed to engage in the business of insurance under Part XII of Chapter 2 of this Title unless preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974. Such term does not include a group health plan.

(c) "Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(d) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(3) "Excepted benefits" means benefits under one or more of the following:

(a) Benefits not subject to requirements.

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Coverage issued as a supplement to liability insurance.

(iii) Liability insurance, including general liability insurance and automobile liability insurance.

(iv) Workers' compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

(viii) Other similar insurance coverage, specified in regulations issued by the commissioner of insurance under the Administrative Procedure Act, under which benefits for medical care are secondary or incidental to other insurance benefits.

(b) Benefits not subject to requirements if offered separately.

(i) Limited scope dental or vision benefits.

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(iii) Such other similar, limited benefits as are specified in reasonable regulations issued by the commissioner of insurance.

(c) Benefits not subject to requirements if offered as independent, noncoordinated benefits.

(i) Coverage only for a specified disease or illness.

(ii) Hospital indemnity or other fixed indemnity insurance.

(d) Benefits not subject to requirements if offered as a separate insurance policy:

(i) Medicare coverage.

(ii) Insurance coverage supplemental to military health benefits.

(iii) Similar supplemental coverage provided under a group health plan.

(4) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(a) A group health plan.

(b) Health insurance coverage.

(c) Medicare coverage provided under 42 USC 1395 et seq.

(d) Medical assistance coverage provided under 42 USC 1396 et seq.

(e) Medical insurance coverage under the General Military Law.

(f) A medical care program of the Indian Health Service or of a tribal organization.

(g) A state health benefits risk pool.

(h) A health plan offered for federal employees.

(i) A public health plan, as defined in regulations promulgated by the commissioner of insurance.

(j) A health benefit plan provided to members of the Peace Corps.

Such term does not include coverage consisting solely of coverage of excepted benefits, as defined in Paragraph (3) of this Section.

(5) Other definitions are:

(a) "Beneficiary" means a person designated by a participant, or by the terms of a health insurance benefit plan, who is or may become entitled to a benefit under the plan.

(b) "Bona fide association" means, with respect to health insurance coverage offered in this state, an association which:

(i) Has been actively in existence for at least five years.

(ii) Has been formed and maintained in good faith for purposes other than obtaining insurance.

(iii) Does not condition membership in the association on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee.

(iv) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members, or individuals eligible for coverage through a member.

(v) Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

(vi) Meets such additional requirements as may be imposed by law.

(c) "COBRA continuation provision" means a provision which complies with R.S. 22:215.13.

(d) "Employee" means any individual employed by an employer.

(e)(i) "Employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

(ii) "Large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

(iii) "Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

(iv) For purposes of this Subparagraph the following persons shall be treated as one employer:

(aa) Corporations which are members of a controlled group of corporations.

(bb) Trades or businesses, whether or not incorporated, which are under common control.

(cc) Affiliated service groups.

(v) In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that is reasonably expected such employer will employ on business days in the current calendar year.

(vi) Any reference in this Subparagraph to an employer shall include a reference to any predecessor of such employer.

(f) "Church plan" means a plan established and maintained for its employees or their beneficiaries by a church or by a convention or association of churches. A plan established and maintained for its employees or their beneficiaries by a church or by a convention or association of churches includes a plan maintained by an organization, whether a civil law corporation or otherwise, the principal purpose or function of which is the administration or funding of a plan or program for the provision of retirement benefits or welfare benefits, or both, for the employees of a church or a convention or association of churches, if such organization is controlled by or associated with a church or a convention or association of churches. The term "church plan" does not include a plan which is established and maintained primarily for the benefit of employees or their beneficiaries of such church or convention or association of churches who are employed in connection with one or more unrelated trades or businesses.

(g)(i) "Governmental plan" means a plan established or maintained for its employees by the government of the United States, by the government of any state or political subdivision thereof, or by any agency or instrumentality of any of the foregoing.

(ii) "Federal governmental plan" means a governmental plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of such government.

(iii) "Nonfederal governmental plan" means a governmental plan that is not a federal governmental plan.

(h) "Health status-related factor" means any of the factors described under R.S. 22:250.3(A)(1).

(i) "Network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract or other participation agreement with the issuer.

(j) "Participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

(k) "Placement" or "being placed", for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(l) "Plan sponsor" means:

(i) The employer in the case of a health benefit plan established or maintained by a single employer.

(ii) The employee organization in the case of a plan established or maintained by an employee organization.

(iii) In the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group or representatives of the parties who establish or maintain the plan.

(m) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan, and includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

(n) "Large group market" means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by a large employer.

(o) "Small group market" means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves, and their dependents, through a group health plan maintained by a small employer.

(p) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

(q) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

(r) "Late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during:

(i) The first period in which the individual is eligible to enroll under the plan.

(ii) A special enrollment period under R.S. 22:250.2(F).

(s) "Waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(t) "Affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(u) "Affiliated service group" means a group consisting of a service organization (hereinafter in this Paragraph referred to as the "first organization") and one or more of the following:

(i) Any service organization which:

(aa) Is a shareholder or partner in the first organization.

(bb) Regularly performs services for the first organization or is regularly associated with the first organization in performing services for third persons.

(ii) Any other organization if:

(aa) A significant portion of the business of such organization is the performance of services of a type historically performed in such service field by employees.

(bb) Ten percent or more of the interests in such organization is held by persons who are highly compensated employees of the first organization or an organization described in Item (i).

(v) "Service organization" means an organization the principal business of which is the performance of services.

(w) "Individual policy" means an accident and health insurance policy or certificate delivered or issued for delivery in this state by an insurer, nonprofit hospital or medical service organization, a domestic nonprofit mutual association which is engaged in the furnishing of hospital services, medical or surgical benefits, a health maintenance organization, or a self-insurance plan.

(x) "Portability" shall mean the exemption of the standard preexisting condition under a subsequent health insurance policy following the termination of a policy or plan from a previous health insurance policy or plan.

Acts 1997, No. 1138, §1, eff. July 14, 1997; Acts 1999, No. 30, §1.

§250.2. Increased portability through limitation on preexisting condition exclusions

A. Limitation on preexisting condition exclusion period; crediting for periods of previous coverage. Subject to the provisions of Subsection D of this Section, a group health plan, and a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(1) Such exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six month period ending on the enrollment date.

(2) Such exclusion extends for a period of not more than twelve months, or eighteen months in the case of a late enrollee, after the enrollment date.

(3) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, as defined in R.S. 22:250.1(4) applicable to the participant or beneficiary as of the enrollment date.

B.(1) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a sixty-three day period during all of which the individual was not covered under any creditable coverage.

(2) For purposes of Paragraph (1) of this Subsection and Paragraph D(4) of this Section, any period that an individual is in a waiting period for any coverage under a group health plan, or for group health insurance coverage, or is in an affiliation period, shall not be taken into account in determining the continuous period.

(3)(a) Except as otherwise provided under Paragraph (2) of this Subsection, a group health plan, and a health insurance issuer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(b) A group health plan, or a health insurance issuer offering group health insurance, may elect to count a period of creditable coverage based on coverage of benefits within each of several classes or categories of benefits specified in regulations promulgated by the commissioner. Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(c) In the case of an election with respect to a group health plan under Subparagraph (b) of this Paragraph, whether or not health insurance coverage is provided in connection with such plan, the plan shall:

(i) Prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election.

(ii) Include in such statements a description of the effect of this election.

(d) In the case of an election under Subparagraph (b) of this Paragraph with respect to health insurance coverage offered by an issuer in the small or large group market, the issuer:

(i) Shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election.

(ii) Shall include in such statements a description of the effect of such election.

(4) Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in Subsection E of this Section or in such other manner as may be specified in regulations.

C. Except as provided in Paragraph (4) of this Subsection, a group health plan and a health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion:

(1) In the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage.

(2) In the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This Paragraph shall not apply to coverage before the date of such adoption or placement for adoption.

(3) Relating to pregnancy as a preexisting condition.

(4) Paragraphs (1) and (2) of this Subsection shall not apply to an individual after the end of the first sixty-three day period during all of which the individual was not covered under any creditable coverage.

D.(1) A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification of the period of creditable coverage:

(a) At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision.

(b) In the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision.

(c) On the request on behalf of an individual made not later than twenty-four months after the date of cessation of the coverage described in Subparagraph (a) or (b) of this Paragraph, whichever is later. The certification under Subparagraph (a) of this Paragraph may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(2) The certification shall include a written certification of the following:

(a) The period of creditable coverage of the individual under such plan and the coverage, if any, under such COBRA continuation provision.

(b) The waiting period, if any, and affiliation period if applicable, imposed with respect to the individual for any coverage under such plan.

(3) To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under Paragraphs (1) and (2) of this Section if the health insurance issuer offering the coverage provides for such certification in accordance therewith.

(4) A plan or issuer providing certification of coverage of an individual pursuant to an election under Subparagraph B(3)(b):

(a) Upon request of the succeeding plan or issuer, shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage.

(b) May charge the requesting plan or issuer for the reasonable cost of disclosing such information.

(5) The commissioner of insurance shall take all appropriate measures to prevent an entity's failure to provide information under this Subsection with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage. Such measures shall include enforcement of all applicable state and federal laws and regulations and adoption of any reasonable regulations required for the enforcement thereof.

E.(1) A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan, or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms, to enroll for coverage under the terms of the plan if each of the following conditions are met:

(a) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(b) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer, if applicable, required such a statement at such time and provided the employee with notice of such requirement, and the consequences of such requirement, at such time.

(c) The employee's or dependent's coverage described in Subparagraph (a) of this Paragraph.

(i) Was under a COBRA continuation provision and the coverage under such provision was exhausted.

(ii) Was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or employer contributions towards such coverage were terminated.

(d) Under the terms of the plan, the employee requests such enrollment not later than thirty days after the date of exhaustion of coverage described in Item (c)(i) of this Paragraph or termination of coverage or employer contribution described in Item (c)(ii) of this Paragraph.

(2)(a) A group health plan shall provide for a dependent special enrollment period during which the person, or, if not otherwise enrolled, the individual, may be enrolled under the plan as a dependent of the individual, if:

(i) A group health plan makes coverage available with respect to a dependent of an individual.

(ii) The individual is a participant under the plan, or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period.

(iii) A person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption. In the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(iv) The dependent was enrolled in the Louisiana Children's Health Insurance Program prior to requesting enrollment in the group health plan, but is no longer eligible to be covered under the Louisiana Children's Health Insurance Program.

(b) A dependent special enrollment period under this Paragraph shall be a period of not less than thirty days and shall begin on:

(i) In the case of marriage, adoption, or placement for adoption, the later of the following: the date dependent coverage is made available or the date of the marriage, adoption, or placement for adoption of a child, as the case may be.

(ii) In the case of a dependent losing eligibility for coverage by the Louisiana Children's Health Insurance Program, the later of the following: the date dependent coverage is made available or the date when coverage under the Louisiana Children's Health Insurance Program ceases.

(c) If an individual seeks to enroll a dependent during the first thirty days of such a dependent special enrollment period, the coverage of the dependent shall become effective as follows:

(i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received.

(ii) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(iii) In the case of a dependent losing eligibility for coverage by the Louisiana Children's Health Insurance Program, the date when such coverage ceases.

F.(1) A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under Subsection A of this Section with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if the following apply:

(a) Such period is applied uniformly without regard to any health status-related factors.

(b) Such period does not exceed two months or three months in the case of a late enrollee.

(2) An affiliation period shall begin on the enrollment date and shall run concurrently with any waiting period under the plan.

(3) A health maintenance organization may use alternative methods to address adverse selection following approval by the commissioner.

Acts 1997, No. 1138, §1, eff. July 14, 1997; Acts 2004, No. 269, §1, eff. June 15, 2004; Acts 2005, No. 47, §1, eff. June 16, 2005.

§250.3. Prohibiting discrimination against individual participants and beneficiaries based on health status

A.(1) Subject to Paragraph (2) of this Subsection, a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(a) Health status.

(b) Medical condition, including both physical and mental illnesses.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions arising out of acts of domestic violence.

(h) Disability.

(2) To the extent consistent with R.S. 22:250.2, Paragraph (1) of this Subsection shall not be construed to do the following:

(a) To require a group health plan, or group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage.

(b) To prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) For purposes of Paragraph (1) of this Subsection, rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

B.(1) A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Nothing in Paragraph (1) of this Subsection shall be construed to do the following:

(a) To restrict the amount that an employer may be charged for coverage under a group health plan.

(b) To prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Acts 1997, No. 1138, §1, eff. July 14, 1997.

§250.4. Standards relating to benefits for mothers and newborns

A.(1) A group health plan, and a health insurance issuer offering group health insurance coverage, and Medical Assistance coverage provided under 42 U.S.C. 1396 et seq., may not, except as provided in Paragraph (2) of this Subsection:

(a) Restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than forty-eight hours.

(b) Restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than ninety-six hours.

(c) Require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under Paragraph (1) of this Subsection, without regard to Paragraph (2) of this Subsection.

(2) The provisions of Paragraph (1) of this Subsection shall not apply in connection with any group health plan or health insurance issuer in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay otherwise required under such Paragraph (1) is made by an attending provider in consultation with the mother.

B. A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, and Medical Assistance coverage provided under 42 U.S.C. 1396 et seq. may not do the following:

(1) Deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this Section.

(2) Provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this Section.

(3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this Section.

(4) Provide incentives, monetary or otherwise, to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this Section.

(5) Subject to the provisions of Paragraph C(3) of this Section, restrict benefits for any portion of a period within a hospital length of stay required under Subsection A of this Section in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

C.(1) Nothing in this Section shall be construed to require a mother who is a participant or beneficiary to do the following:

(a) To give birth in a hospital.

(b) To stay in the hospital for a fixed period of time following the birth of her child.

(2) This Section shall not apply with respect to any group health plan, or any group health insurance coverage offered by a health insurance issuer, which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) Nothing in this Section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan, or under health insurance coverage offered in connection with a group health plan, except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under Subsection A of this Section may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

D.(1) A summary plan description of any group health plan shall be furnished to participants and beneficiaries. The summary plan description shall:

(a) Include the information described in Paragraph (3) of this Subsection.

(b) Be written in a manner calculated to be understood by the average plan participant.

(c) Be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.

(2) A summary of any material modification in the terms of the plan and any change in the information required under Paragraph (3) of this Subsection shall be written in a manner calculated to be understood by the average plan participant and shall be furnished within ninety days after he becomes a participant or after he first receives benefits. If later, the information shall be furnished one hundred twenty days after the plan becomes subject to this Part.

(3) The plan description and summary plan description shall contain the following information:

(a) The name and type of administration of the plan.

(b) The name and address of the person designated as agent for the service of legal process, if such person is not the administrator.

(c) The name and address of the administrator.

(d) The names, titles, and addresses of any trustee or trustees if they are persons different from the administrator.

(e) A description of the relevant provisions of any applicable collective bargaining agreement.

(f) The plan's requirements respecting eligibility for participation and benefits.

(g) A description of the provisions providing for nonforfeitable pension benefits.

(h) The circumstances which may result in disqualification, ineligibility, or denial or loss of benefits.

(i) The source of financing of the plan and the identity of any organization through which benefits are provided.

(j) The date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis.

(k) The procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part.

E. Nothing in this Section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this Section.

F.(1) Notwithstanding any other provisions to the contrary, a newborn child upon birth shall be enrolled as a dependent under a group health plan, policy, or certificate of coverage issued by a health insurance issuer, effective as of the date of such birth, under which such newborn child may be enrolled.

(2) If applicable, the premium for a newborn child added to a policy, plan, or certificate of coverage may be subject to adjustment for the additional coverage provided. Such coverage shall be effective as of the date of birth of such newborn child and pursuant to applicable provisions of the policy, plan, or certificate, shall be subject to the payment of such additional premium, if any, and receipt of any required enrollment information within the time period required by the health insurance issuer.

(3) To the extent that such newborn child meets, at birth, the eligibility provisions as set forth in state laws, rules, or regulations implementing the State Plan Medical Assistance under Title XIX of the Social Security Act, such additional coverage shall not be cancelled for nonpayment of any additional premium due, if any, prior to the health insurance issuer giving the secretary of the Louisiana Department of Health and Hospitals ninety days written notice thereof via United States mail, certified, return receipt requested. If the premium remains unpaid after the notice period, the health insurance issuer may cancel the newborn child's coverage effective as of the birth of the newborn child. The health insurance issuer shall mail a copy of the notice provided to the secretary of the Department of Health and Hospitals to each health care provider that has submitted a claim for services rendered to the newborn child. The health insurance issuer shall mail the copy of the notice no later than three days after mailing the notice to the secretary of the Department of Health and Hospitals.

Acts 1997, No. 1138, §1, eff. July 14, 1997; Acts 2004, No. 269, §1, eff. June 15, 2004.

§250.5. Parity in the application of certain limits to mental health benefits

A.(1) In the case of a group health plan, or health insurance coverage offered in connection with such a plan, that provides both medical and surgical benefits and mental health benefits:

(a) If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.

(b) If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits, in this Paragraph referred to as the "applicable lifetime limit", the plan or coverage shall do one of the following:

(i) Apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits.

(ii) Not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

(c) In the case of a plan or coverage that is not described in Subparagraph (a) or (b) of this Paragraph and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the commissioner shall establish rules under which Subparagraph (b) of this Paragraph is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) In the case of a group health plan, or health insurance coverage offered in connection with such a plan, that provides both medical and surgical benefits and mental health benefits:

(a) If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits.

(b) If the plan or coverage includes an annual limit on substantially all medical and surgical benefits, in this Paragraph referred to as the "applicable annual limit", the plan or coverage shall do one of the following:

(i) Apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits.

(ii) Not include any annual limit on mental health benefits that is less than the applicable annual limit.

(c) In the case of a plan or coverage that is not described in Subparagraph (a) or (b) and that includes no or different annual limits on different categories of medical and surgical benefits, the plan shall comply with all applicable federal regulations under which Subparagraph (b) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

B. Except as provided in Subsection A, nothing in this Section shall be construed to do the any of the following:

(1) Require a group health plan, or health insurance coverage offered in connection with such a plan, to provide any mental health benefits.

(2) Affect the terms and conditions of a group health plan, or health insurance coverage offered in connection with such a plan, that provides mental health benefits. Terms and conditions shall include cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity, relating to the amount, duration, or scope of mental health benefits under the plan or coverage.

C.(1) This Section shall not apply to any group health plan, and group health insurance coverage offered in connection with a group health plan, for any plan year of a small employer.

(2) This Section shall not apply with respect to a group health plan, or health insurance coverage offered in connection with a group health plan, if the application of this Section to such plan or to such coverage results in an increase in the cost under the plan or for such coverage of at least one percent.

D. In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this Section shall be applied separately with respect to each such option.

E. For purposes of this Section, the following terms are defined as follows:

(1) "Aggregate lifetime limit" means a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

(2) "Annual limit" means a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a twelve-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

(3) "Medical or surgical benefits" means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage, as the case may be, but does not include mental health benefits.

(4) "Mental health benefits" means benefits with respect to mental health services, as defined under the terms of the plan or coverage, as the case may be, but does not include benefits with respect to treatment of substance abuse or chemical dependency.

F. REPEALED BY ACTS 2001, No. 66, §1, eff. Sept. 30, 2001.

Acts 1997, No. 1138, §1, eff. July 14, 1997; Acts 1999, No. 30, §1; Acts 2001, No. 66, §1, eff. Sept. 30, 2001.

§250.6. Guaranteed availability of coverage for employers in the group market

A.(1) Except as provided in Subsections B through E of this Section, each health insurance issuer that offers health insurance coverage in the small group market shall do the following:

(a) Accept every small employer, as defined in R.S. 22:250.1(5)(e), in the state that applies for such coverage.

(b) Accept for enrollment under such coverage every eligible individual, as defined in Paragraph (2) of this Subsection, who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health plan and may not place any restriction which is inconsistent with R.S. 22:250.3 on an eligible individual being a participant or beneficiary.

(2) For purposes of this Section, the term "eligible individual" means, with respect to a health insurance issuer that offers health insurance coverage to a small employer in connection with a group health plan in the small group market, such an individual in relation to the employer as shall be determined as follows:

(a) In accordance with the terms of such plan.

(b) As provided by the issuer under rules of the issuer which are uniformly applicable in this state to small employers in the small group market.

(c) In accordance with all applicable state laws governing such issuer and such market.

B.(1) In the case of a health insurance issuer that offers health insurance coverage in the small group market through a network plan, the issuer may do the following:

(a) Limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan.

(b) Within the service area of such plan, deny such coverage to such employers if the issuer has demonstrated to the commissioner of insurance each of the following:

(i) It will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees.

(ii) It is applying this Paragraph uniformly to all employers without regard to the claims experience of those employers and their employees, and their dependents, or any health status-related factor relating to such employees and dependents.

(2) An issuer, upon denying health insurance coverage in any service area in accordance with Subparagraph (1)(b) of this Subsection, may not offer coverage in the small group market within such service area for a period of one hundred eighty days after the date such coverage is denied.

C.(1) A health insurance issuer may deny health insurance coverage in the small group market if the issuer has demonstrated, if required, to the commissioner of insurance each of the following:

(a) It does not have the financial reserves necessary to underwrite additional coverage.

(b) It is applying this Paragraph uniformly to all employers in the small group market in the state consistent with applicable state law and without regard to the claims experience of those employers and their employees, and their dependents, or any health status-related factor relating to such employees and dependents.

(2) A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with Paragraph (1) of this Subsection in this state may not offer coverage in connection with group health plans in the small group market in this state for a period of one hundred eighty days after the date such coverage is denied or until the issuer has demonstrated to the commissioner of insurance, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. The commissioner of insurance may issue reasonable regulations for the application of this Subsection on a service-area-specific basis.

D.(1) The provisions of Subsection A of this Section shall not be construed to preclude a health insurance issuer from establishing employer contribution rules or uniform group participation rules for the offering of health insurance coverage in connection with a group health plan in the small group market, as allowed under applicable state law.

(2)(a) The term "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries.

(b) The term "group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer, but in no event shall any plan require greater than seventy-five percent participation of eligible individuals.

E. Exception for coverage offered only to bona fide association members. The provisions of Subsection A of this Section shall not apply to health insurance coverage offered by a health insurance issuer if such coverage is made available in the small group market only through one or more bona fide associations as defined in R.S. 22:250.1 (5)(b).

Acts 1997, No. 1138, §1, eff. July 14, 1997.

§250.7. Guaranteed renewability of coverage for employers in the group market

A. Except as provided in this Section, if a health insurance issuer offers health insurance coverage in the small or large group market in connection with a group health plan, the issuer must renew or continue in force such coverage at the option of the plan sponsor of the plan.

B. A health insurance issuer may non-renew or discontinue health insurance coverage offered in connection with a group health plan in the small or large group market based only on one or more of the following:

(1) The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) The plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under R.S. 22:250.6(D) in the case of the small group market or pursuant to applicable state law in the case of the large group market.

(4) The issuer is ceasing to offer coverage in such market in accordance with Subsection C of this Section and applicable state law.

(5) In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the issuer, or in the area for which the issuer is authorized to do business, and, in the case of the small group market, the issuer would deny enrollment with respect to such plan under R.S. 22:250.6(B)(1)(a).

(6) In the case of health insurance coverage that is made available in the small or large group market, as the case may be, only through one or more bona fide associations, the membership of an employer in the association, on the basis of which the coverage is provided, ceases but only if such coverage is terminated under this Paragraph uniformly without regard to any health status-related factor relating to any covered individual.

C.(1) In any case in which an issuer decides to discontinue offering a particular type of group health insurance coverage offered in the small or large group market, coverage of such type may be discontinued by the issuer in such market only if:

(a) The issuer provides notice to each plan sponsor provided coverage of this type in such market, and participants and beneficiaries covered under such coverage, of such discontinuation at least ninety days prior to the date of the discontinuation of such coverage.

(b) The issuer offers to each plan sponsor provided coverage of this type in such market, the option to purchase all, or, in the case of the large group market, any other health insurance coverage currently being offered by the issuer to a group health plan in such market.

(c) In exercising the option to discontinue coverage of this type and in offering the option of coverage under Subparagraph (b) of this Paragraph, the issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(d) Prior to providing the notice required by Subparagraph (a) of this Paragraph, the issuer files such notice and the insurance product being discontinued with the commissioner of insurance.

(2)(a) In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in the state, health insurance coverage may be discontinued by the issuer if:

(i) The issuer provides notice to the commissioner of insurance and to each plan sponsor, and participants and beneficiaries covered under such coverage, of such discontinuation at least one hundred eighty days prior to the date of the discontinuation of such coverage.

(ii) All health insurance issued or delivered for issuance in this state in such market or markets is discontinued and coverage under such health insurance coverage in such market or markets is not renewed.

(iii) Prior to providing the notice required by Item (i) of this Subparagraph, the issuer files such notice and the insurance product being discontinued with the commissioner of insurance.

(b) In the case of a discontinuation under Subparagraph (a) of this Paragraph in a market, the issuer may not provide for the issuance of any health insurance coverage in the market and state during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(3) No health insurance issuer shall not renew any policy or contract of coverage in the small or large group market prior to the end of the last period of coverage as stated in such policy or contract.

D. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan:

(1) In the large group market.

(2) In the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is approved by the commissioner and is effective on a uniform basis among group health plans with that product.

E. In applying this Section in the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, a reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

F. The Department of Insurance shall have the authority, pursuant to the Administrative Procedure Act, to promulgate and adopt rules and regulations necessary to implement the provisions of this Section.

Acts 1997, No. 1138, §1, eff. July 14, 1997; Acts 1999, No. 127, §1, eff. June 9, 1999.

§250.8. Disclosure of information

A. In connection with the offering of any health insurance coverage to a small employer, a health insurance issuer shall make a reasonable disclosure to such employer, as part of its solicitation and sales materials, of the availability of information described in Subsection B of this Section and upon request of such a small employer, provide such information.

B.(1) Subject to the provisions of Subsection C of this Section, information described in this Section is information concerning:

(a) The provisions of such coverage concerning the issuer's right to change premium rates and the factors that may affect changes in premium rates.

(b) The provisions of such coverage relating to renewability of coverage.

(c) The provisions of such coverage relating to any preexisting condition exclusion.

(d) The benefits and premiums available under all health insurance coverage for which the employer is qualified.

(2) Information under this Subsection shall be provided to small employers in a manner determined to be understandable by the average small employer, and shall be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

C. An issuer is not required under this Section to disclose any information that is proprietary and trade secret information under applicable law.

Acts 1997, No. 1138, §1, eff. July 14, 1997.

§250.9. Exclusion of certain plans

A. The requirements of this Part shall not apply to any group health plan, and health insurance coverage offered in connection with a group health plan, for any plan year if, on the first day of such plan year, such plan has less than two participants who are current employees.

B.(1) The requirements of this Part shall apply with respect to group health plans only with respect to health insurance coverage offered in connection with a group health plan, including such a plan that is a church plan or a government plan.

(2) Any nonfederal government plan that has not adopted one or more of the requirements of this Part may submit an implementation waiver request to the Department of Insurance for review and approval. Any request to waive implementation, approved by the Department of Insurance, shall expire on or before June 30, 2001. Requests to waive implementation of the provisions of this Part shall meet the following requirements:

(a) The nonfederal government plan shall provide written notice to each employee of the requirements that have not been implemented and the actions that will be taken to assure full compliance prior to the expiration of any waiver granted.

(b) The nonfederal government plan shall notify the public through publication of those requirements that have not been met, the impact on employees and their families, and include a statement of the actions that will be taken to assure full compliance prior to the expiration of any waiver granted.

(3) Any waiver of implementation approved shall be subject to renewal after the first twelve months provided satisfactory progress in implementing the provisions of this Subsection is demonstrated by the nonfederal government plan to the department. Waivers approved under this Subsection shall be limited to nonfederal government plans which had not implemented the provisions of this Part prior to January 1, 1999.

C. The requirements of this Part shall not apply to any group health plan, or group health insurance coverage, in relation to its provision of excepted benefits described in R.S. 22:250.1(3)(a).

D.(1) The requirements of this Part shall not apply to any group health plan, and group health insurance coverage offered in connection with a group health plan, in relation to its provision of excepted benefits described in R.S. 22:250.1(3)(b) if the benefits:

(a) Are provided under a separate policy, certificate, or contract of insurance.

(b) Are otherwise not an integral part of the plan.

(2) The requirements of this Part shall not apply to any group health plan, and group health insurance coverage offered in connection with a group health plan, in relation to its provision of excepted benefits described in R.S. 22:250.1(3)(c) if all of the following conditions are met:

(a) The benefits are provided under a separate policy, certificate, or contract of insurance.

(b) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

(c) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

(3) The requirements of this Part shall not apply to any group health plan, and group health insurance coverage, in relation to its provision of excepted benefits described in R.S. 22:250.1(3)(d) if the benefits are provided under a separate policy, certificate, or contract of insurance.

E. For purposes of this Section:

(1) Any plan, fund, or program which would not be, but for the provisions of this Paragraph, an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership or to their dependents, as defined under the terms of the plan, fund, or program, directly or through insurance, reimbursement, or otherwise, shall be treated, subject to the provisions of Paragraph (2)[1] of this Subsection, as an employee welfare benefit plan which is a group health plan.

(2) The term "employer" also includes the partnership in relation to any partner.

(3) The term "participant" also includes:

(a) In connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership.

(b) In connection with a group health plan maintained by a self-employed individual, under which one or more employees are participants, the self-employed individual, if such individual is, or may become, eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

Acts 1997, No. 1138, §1, eff. July 14, 1997; Acts 1999, No. 29, §1.

[1]As appears in enrolled bill.

§250.10. Enforcement provisions

A. Health insurance issuers that issue, sell, renew, or offer health insurance coverage in this state in the small or large group markets shall meet the requirements of this Part with respect to such issuers.

B. The commissioner of insurance shall enforce the provisions of this Part and is authorized to enter into agreements with the federal government for enforcement of federal statutes, rules, policy issuances, and guidelines insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in connection with group health plans.

C.(1) Any nonfederal governmental plan that is a group health plan and any health insurance issuer that fails to meet a provision of this Part, or provisions included under an agreement with the federal government for the enforcement of federal statutes, applicable to such plan or issuer shall be subject to a civil money penalty under this Subsection.

(2) In the case of a failure by:

(a) A health insurance issuer, the issuer is liable for such penalty.

(b) A group health plan that is a nonfederal governmental plan which is:

(i) Sponsored by two or more employers, the plan is liable for such penalty, or

(ii) Not so sponsored, the employer is liable for such penalty.

(3)(a) The maximum amount of penalty imposed under this Subsection is one hundred dollars for each day for each individual with respect to which such a failure occurs.

(b) In determining the amount of any penalty to be assessed under this Paragraph, the commissioner of insurance shall take into account the previous record of compliance of the entity being assessed with the applicable provisions of this Part and the gravity of the violation.

(c)(i) No civil money penalty shall be imposed under this Paragraph on any failure during any period for which it is established to the satisfaction of the commissioner of insurance that none of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(ii) No civil money penalty shall be imposed under this Paragraph on any failure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the thirty-day period beginning on the first day any of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(d) The entity assessed shall be afforded an opportunity for hearing in accordance with Part XXIX of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950, by the commissioner of insurance upon request made within thirty days after the date of the issuance of a notice of assessment.

D.(1) Penalties collected for enforcement of this Part or enforcement of agreements with the federal government shall be paid to the Department of Insurance.

(2)(a) In addition to all other taxes and assessments, each insurer subject to this Part shall be assessed on July first of each year and by July thirtieth of each year shall pay to the commissioner of insurance a sum not to exceed five one-hundredths of one percent of the amount of premiums received in this state by such insurer during the preceding year ending December thirty-first.

(b) On March first of each year, each insurer shall file with the commissioner of insurance a form provided by the commissioner of insurance, which shall include information requested by the commissioner to determine the total premiums received by each insurer subject to this Part in the preceding calendar year and for the commissioner to calculate the basis of the July first assessment.

(c) The commissioner shall provide notice of the annual assessment percentage amount for each calendar year which shall be published in the state register no later than July first.

(d) The commissioner shall establish the annual assessment percentage amount based on the cost of administering and enforcing the provisions of this Part. In determining the cost of administering and enforcing the provisions of this Part, the commissioner shall deduct any amounts collected from penalties imposed which are available and appropriated for use.

(3)(a) Funds received by the Department of Insurance from such assessments and penalties shall be deposited immediately upon receipt into the state treasury.

(b) After compliance with the requirements of Article VII, Section 9(B) of the Constitution of Louisiana relative to the Bond Security and Redemption Fund, and prior to monies being placed in the state general fund, an amount equal to that deposited as required by Subparagraph (a) of this Paragraph shall be credited to a special fund hereby created in the state treasury to be known as the Administrative Fund of the Department of Insurance. The monies in this fund shall be used solely as provided by Subparagraph (c) of this Paragraph and only in the amounts appropriated by the legislature. All unexpended and unencumbered monies in this fund at the end of the fiscal year shall remain in such fund. The monies in this fund shall be invested by the state treasurer in the same manner as monies in the state general fund and interest earned on the investment of these monies shall be credited to this fund.

(c) The monies in the Administrative Fund of the Department of Insurance shall be used solely for the expenses in connection with the administration and enforcement of the provisions of this Part.

Acts 1997, No. 1138, §1, eff. July 14, 1997; Acts 1999, No. 445, §1, eff. June 18, 1999; Acts 2001, No. 63, §1, eff. May 24, 2001.

§250.11. Individual health insurance coverage portability and limitation on preexisting condition exclusions; newborn coverage; coordination of benefits

A. The coverage for an insured under individual health insurance coverage shall be subject to the provisions of this Section.

B. The provisions of this Section shall not preclude the standard twelve-month preexisting condition exclusions when the covered person initially becomes covered under a health and accident insurance policy or health maintenance organization subscriber agreement or when a covered person lacks continuous health insurance coverage for a period in excess of sixty-three days. In determining whether a preexisting condition exclusion applies to a covered person, any health and accident insurance policy or health maintenance organization subscriber agreement covered by this Section shall credit the time the person was covered under a previous policy covered by this Section, if the previous coverage was continuous to a date not more than sixty-three days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such policy.

C. Notwithstanding the provisions of Subsections B and D of this Section, individual health insurance coverage offered to any individual may exclude coverage for medical care for specific medical conditions that existed prior to the issuance of coverage, subject to the following conditions:

(1) The exclusion of coverage for medical care shall not apply to any services, benefits, or options mandated by state or federal law to be included in a policy or certificate of coverage.

(2) The exclusion of coverage for medical care shall be for a specified period of time longer than twelve months and shall cover a specific medical condition.

(3) Before or at the time of issuance of the policy or subscriber agreement, the health insurance issuer shall provide the applicant with a written notice explaining the exclusion of coverage for the specific medical condition. Such exclusion of coverage shall not be applied to any other medical condition not arising directly as the result of the specific medical condition being excluded.

(4) The offer of coverage shall state that the applicant is receiving coverage with an exclusion of coverage for a specific medical condition. Such statement shall be printed in bold print as a separate section of the policy or subscriber agreement or on a separate form.

(5) The offer of coverage shall not include more than two specific medical conditions being excluded from coverage per individual covered under the policy or subscriber agreement.

(6) The exclusion period shall be concurrent with any other applicable preexisting condition limitation or exclusion period.

(7) The health insurance issuer shall agree to review the underwriting basis for the exclusion from coverage upon written request by the insured no more often than once in a twelve-month period. The issuer shall remove the exclusion, effective upon renewal, if the insurer determines that the evidence of insurability is satisfactory.

(8) The insured's benefit card shall disclose the telephone number where exclusions can be verified.

D. Any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, health and accident insurance policy, or any other insurance contract of this type, or a self-insurance plan, which is delivered, issued for delivery, or renewed in this state shall not deny, exclude, or limit benefits for a covered individual for losses due to a preexisting condition incurred more than twelve months following the effective date of the covered person's coverage unless an exclusion of coverage is established pursuant to Subsection C of this Section. The provisions of this Section shall not apply to limited benefit and supplemental health insurance policies nor to short-term major medical policies of a duration of six months or less. Any policy, contract, or plan subject to the provisions of this Section shall not contain a definition of a preexisting condition more restrictive than the following:

(1) A condition that would have caused an ordinary prudent person to seek medical advice, diagnosis, care, or treatment during the twelve months immediately preceding the effective date of coverage.

(2) A condition for which medical advice, diagnosis, care or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage.

(3) A pregnancy existing on the effective date of coverage.

E. Any individual policyholder or individual subscriber shall be authorized to add a newborn child to his individual policy or subscriber agreement at any time prior to birth or at birth as set forth in R.S. 22:250.15(A), effective upon birth. Coverage for a newborn child added to a policy or subscriber agreement pursuant to this Subsection shall be subject to adjustment for the additional coverage provided.

F. Individual health insurance coverage shall be subject to coordination of benefits with other health insurance coverage and treated as secondary to any group health insurance coverage in effect. In no instance shall a health insurance issuer be required to pay any amount in excess of the benefit amount that would have been paid under a policy or subscriber agreement if no other group health insurance coverage was in effect.

Acts 1997, No. 1138, §1, eff. July 14, 1997; Acts 1999, No. 616, §1; Acts 2001, No. 133, §1, eff. May 25, 2001; Acts 2004, No. 269, §1, eff. June 15, 2004.

§250.12. Guaranteed availability of individual health insurance coverage to certain individuals with prior group or individual coverage

A.(1) Except as otherwise provided for in this Section, each health insurance issuer that offers health insurance coverage, as defined in R.S. 22:250.1(2)(a), in the individual market of the state may not, with respect to an eligible individual, as defined in Subsection B of this Section, desiring to enroll in individual health insurance coverage:

(a) Decline to offer such coverage to, or deny enrollment of, such individual.

(b) Impose any preexisting condition exclusion, as defined in R.S. 22:250.1(5)(p), with respect to such coverage.

(2) The requirement of Subparagraph (1)(a) of this Subsection shall not apply to health insurance coverage offered in the individual market where the state has adopted an alternative mechanism authorized by the Health Insurance Portability and Accountability Act of 1996 which has not been found to be unacceptable by the secretary of the United States Department of Health and Human Services.

B. As used in this Section, the term "eligible individual" means an individual who meets the requirements of Subsection H of this Section or an individual:

(1)(a) For whom, as of the date on which the individual seeks coverage under this Section, the aggregate of the periods of creditable coverage is eighteen or more months.

(b) Whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan, or health insurance coverage offered in connection with any such plan.

(2) Who does not have other insurance coverage and is not eligible for coverage under:

(a) A group health plan.

(b) Medicare coverage under 42 USC 1395 et seq.

(c) A state Medicaid program or any successor program.

(3) With respect to whom the most recent coverage within the coverage period described in Subparagraph (1)(a) of this Subsection was not terminated based on a factor described in R.S. 22:250.7(B)(1) or (2), relating to nonpayment of premiums or fraud.

(4) Who elected coverage under a COBRA continuation provision or under a similar state program.

(5) Who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

C.(1) In the case of health insurance coverage offered in the individual market where the state has not adopted an acceptable alternative mechanism, the health insurance issuer may elect to limit the coverage offered under Subsection A of this Section so long as it offers at least two different policy forms of health insurance coverage both of which:

(a) Are designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals by the issuer.

(b) Meet the requirement of Paragraph (2) or (3) of this Subsection, as elected by the issuer. For purposes of this Subsection, policy forms which have different cost-sharing arrangements or different riders shall be considered to be different policy forms.

(2) The requirement of this Paragraph is met, for health insurance coverage policy forms offered by an issuer in the individual market, if the issuer offers the policy forms for individual health insurance coverage with the largest, and next to largest, premium volume of all such policy forms offered by the issuer in the state or applicable marketing or service area, as may be prescribed in regulation, by the issuer in the individual market in the period involved.

(3)(a) The requirement of this Paragraph is met, for health insurance coverage policy forms offered by an issuer in the individual market, if the issuer offers a lower-level coverage policy form, as defined in Subparagraph (b) of this Paragraph, and a higher-level coverage policy form, as defined in Subparagraph (c) of this Paragraph, each of which includes benefits substantially similar to other individual health insurance coverage offered by the issuer in the state and each of which provides for risk adjustment, risk spreading, or a risk spreading mechanism, among the policies of an issuer or otherwise provides for some financial subsidization for eligible individuals.

(b) A policy form is described in this Subparagraph if the actuarial value of the benefits under the coverage is at least eighty-five percent but not greater than one hundred percent of a weighted average, described in Subparagraph (d) of this Paragraph.

(c) A policy form is described in this Subparagraph if

(i) The actuarial value of the benefits under the coverage is at least fifteen percent greater than the actuarial value of the coverage described in Subparagraph (b) of this Paragraph offered by the issuer in the state.

(ii) The actuarial value of the benefits under the coverage is at least one hundred percent but not greater than one hundred and twenty percent of a weighted average, described in Subparagraph (d) of this Paragraph.

(d) For purposes of this Paragraph, the weighted average described in this Subparagraph is the average actuarial value of the benefits provided by all the health insurance coverage issued, as elected by the issuer, either by that issuer or by all issuers in the state in the individual market during the previous year, not including coverage issued under this Section, weighted by enrollment for the different coverage.

(4) The issuer elections under this Subsection shall apply uniformly to all eligible individuals in the state for that issuer. Such an election shall be effective for policies offered during a period of not shorter than two years.

(5) For purposes of Paragraph (3) of this Subsection, the actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

D.(1) In the case of a health insurance issuer that offers health insurance coverage in the individual market through a network plan, the issuer may:

(a) Limit the individuals who may be enrolled under such coverage to those who live, reside, or work within the service area for such network plan.

(b) Within the service area of such plan, deny such coverage to such individuals if the issuer has demonstrated to the commissioner of insurance that:

(i) It will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders and enrollees and individual enrollees.

(ii) It is applying this Paragraph uniformly to individuals without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

(2) An issuer, upon denying health insurance coverage in any service area in accordance with Subparagraph (1)(b) of this Subsection, may not offer coverage in the individual market within such service area for a period of one hundred eighty days after such coverage is denied.

E.(1) A health insurance issuer may deny health insurance coverage in the individual market to an eligible individual if the issuer has demonstrated to the commissioner of insurance that:

(a) It does not have the financial reserves necessary to underwrite additional coverage.

(b) It is applying this Paragraph uniformly to all individuals in the individual market in the state consistent with applicable state law and without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

(2) An issuer upon denying individual health insurance coverage in any service area in accordance with Paragraph (1) of this Subsection may not offer such coverage in the individual market within such service area for a period of one hundred eighty days after the date such coverage is denied or until the issuer has demonstrated to the commissioner of insurance that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. The commissioner of insurance may apply the requirements of this Paragraph on a service-area-specific basis.

F.(1) The provisions of Subsection A of this Section shall not be construed to require that a health insurance issuer offering health insurance coverage only in connection with group health plans or through one or more bona fide associations, or both, offer such health insurance coverage in the individual market.

(2) A health insurance issuer offering health insurance coverage in connection with group health plans under this Part shall not be deemed to be a health insurance issuer offering individual health insurance coverage solely because such issuer offers a conversion policy.

G. Nothing in this Section shall be construed:

(1) To restrict the amount of the premium rates that an issuer may charge an individual for health insurance coverage provided in the individual market under applicable state law.

(2) To prevent a health insurance issuer offering health insurance coverage in the individual market from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

H. For purposes of this Section, "eligible individual" also means an individual who has had his individual health insurance coverage discontinued pursuant to R.S. 22:250.13(C) and who is a resident of this state:

(1) For whom, as of the date on which the individual seeks coverage under this Section, the aggregate of the periods of continuous health insurance coverage in this state is eighteen or more months with no breaks in such coverage in excess of sixty-three days.

(2) Whose most recent prior creditable coverage was under individual health insurance coverage.

(3) Who does not have other health insurance coverage and is not eligible for coverage under:

(a) A group health plan.

(b) Medicare coverage under 42 USC 1395 et seq.

(c) A state Medicaid program or any successor program.

(d) An offer of individual health insurance coverage by a health insurance issuer that does not include exclusions from coverage.

(4) With respect to whom the most recent coverage within the coverage period described in Paragraph (1) of this Subsection was not terminated based on a factor described in R.S. 22:250.13(B)(1) or (2) relating to nonpayment of premiums or fraud.

Acts 1997, No. 1138, §1, eff. July 14, 1997; Acts 2001, No. 174, §1, eff. May 31, 2001.

§250.13. Guaranteed renewability of individual health insurance coverage

A. Except as provided in this Section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual.

B. A health insurance issuer may non-renew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) The issuer is ceasing to offer coverage in the individual market in accordance with Subsection C of this Section and applicable state law.

(4) In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area, or in an area for which the issuer is authorized to do business, but only if such coverage is terminated under this Paragraph uniformly without regard to any health status-related factor of covered individuals.

(5) In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association, on the basis of which the coverage is provided, ceases but only if such coverage is terminated under this Paragraph uniformly without regard to any health status-related factor of covered individuals.

C.(1) In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the issuer only if:

(a) The issuer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least ninety days prior to the date of the discontinuation of such coverage.

(b) The issuer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in such market.

(c) In exercising the option to discontinue coverage of this type and in offering the option of coverage under Subparagraph (b) of this Paragraph, the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

(d) Prior to providing the notice required by Subparagraph (a) of this Paragraph, the issuer files such notice and the insurance product being discontinued with the commissioner of insurance.

(2)(a) Subject to Subparagraph (b) of this Paragraph, in any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in a state, health insurance coverage may be discontinued by the issuer only if:

(i) The issuer provides notice to the applicable state authority and to each individual of such discontinuation at least one hundred eighty days prior to the date of the expiration of such coverage.

(ii) All health insurance issued or delivered for issuance in the state in such market are discontinued and coverage under such health insurance coverage in such market is not renewed.

(iii) Prior to providing the notice required by Item (i) of this Subparagraph, the issuer files such notice and the insurance product being discontinued with the commissioner of insurance.

(b) In the case of a discontinuation under Subparagraph (a) of this Paragraph in the individual market, the issuer may not provide for the issuance of any health insurance coverage in the market and state involved during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(3) No health insurance issuer shall not renew any policy or contract of coverage in the individual market prior to the end of the last period of coverage as stated in such policy or contract.

D. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with state law and effective on a uniform basis among all individuals with that policy form.

E. In applying this Section in the case of health insurance coverage that is made available by a health insurance issuer in the individual market to individuals only through one or more associations, a reference to an "individual" is deemed to include a reference to such an association, of which the individual is a member.

F. The Department of Insurance shall have the authority, pursuant to the Administrative Procedure Act, to promulgate and adopt rules and regulations necessary to implement the provisions of this Section.

Acts 1997, No. 1138, §1, eff. July 14, 1997; Acts 1999, No. 127, §1, eff. June 9, 1999.

§250.14. Certification of coverage

The provisions of R.S. 22:250.2(D) shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

Acts 1997, No. 1138, §1, eff. July 14, 1997.

§250.15. Standards relating to benefits for mothers and newborns

A.(1) The provisions of R.S. 22:250.4(A), (B), and (C) shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

(2) Notwithstanding any other provisions to the contrary, a newborn child upon birth shall be enrolled as a dependent under a group health plan, policy, or certificate of coverage issued by a health insurance issuer, effective as of the date of such birth, under which such newborn child may be enrolled.

(3) If applicable, the premium for a newborn child added to a policy, plan, or certificate of coverage may be subject to adjustment for the additional coverage provided. Such coverage shall be effective as of the date of birth of such newborn child and pursuant to applicable provisions of the policy, plan, or certificate, shall be subject to the payment of such additional premium, if any, and receipt of any required enrollment information within the time period required by the health insurance issuer.

(4) To the extent that such newborn child meets, at birth, the eligibility provisions as set forth in state laws, rules, or regulations implementing the State Plan Medical Assistance under Title XIX of the Social Security Act, such additional coverage shall not be cancelled for nonpayment of any additional premium due, if any, prior to the health insurance issuer giving the secretary of the Louisiana Department of Health and Hospitals ninety days written notice thereof via United States mail, certified, return receipt requested.

(5) If the premium remains unpaid after the notice period, the health insurance issuer may cancel the newborn child's coverage effective as of the birth of the newborn child. The health insurance issuer shall mail a copy of the notice provided to the secretary of the Department of Health and Hospitals to each health care provider that has submitted a claim for services rendered to the newborn child. The health insurance issuer shall mail the copy of the notice no later than three days after mailing the notice to the secretary of the Department of Health and Hospitals.

B.(1) A summary plan description of any individual health plan shall be furnished to participants and beneficiaries. The summary plan description shall:

(a) Include the information described in Paragraph (3) of this Subsection.

(b) Be written in a manner calculated to be understood by the average plan participant.

(c) Be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.

(2) A summary of any material modification in the terms of the plan and any change in the information required under Paragraph (3) of this Subsection shall be written in a manner calculated to be understood by the average plan participant and shall be furnished within ninety days after he becomes a participant or after he first receives benefits. If later, the information shall be furnished one hundred twenty days after the plan becomes subject to this Part.

(3) The plan description and summary plan description shall contain the following information:

(a) The name and type of administration of the plan.

(b) The name and address of the person designated as agent for the service of legal process, if such person is not the administrator.

(c) The name and address of the administrator.

(d) The names, titles, and addresses of any trustee or trustees if they are persons different from the administrator.

(e) A description of the relevant provisions of any applicable collective bargaining agreement.

(f) The plan's requirements respecting eligibility for participation and benefits.

(g) A description of the provisions providing for nonforfeitable pension benefits.

(h) The circumstances which may result in disqualification, ineligibility, or denial or loss of benefits.

(i) The source of financing of the plan and the identity of any organization through which benefits are provided.

(j) The date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis.

(k) The procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part.

Acts 1997, No. 1138, §1, eff. July 14, 1997; Acts 2004, No. 269, §1, eff. June 15, 2004.

§250.16. General exceptions

A. The requirements of this Part shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in R.S. 22:250.1(3)(a).

B. The requirements of this Part shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in R.S. 22:250.1(3)(b), (c), or (d) if the benefits are provided under a separate policy, certificate, or contract of insurance.

Acts 1997, No. 1138, §1, eff. July 14, 1997.

§250.17. Required coverage for reconstructive surgery following mastectomies

A. A group health plan, a health insurance insurer providing health insurance coverage in connection with a group health plan, or health insurance coverage offered by a health insurance insurer in the individual market that provides medical and surgical benefits with respect to a mastectomy shall provide, in the case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for reconstruction of the breast on which the mastectomy has been performed, coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance, and coverage for prostheses and physical complications, all states of mastectomy, including lymphedemas and such coverage shall be in a manner determined in consultation with the attending physician and the patient. The coverage provided in this Section may be subject to annual deductibles, coinsurance, and copayment provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of coverage shall be delivered to the participant upon enrollment and annually thereafter as approved by the commissioner of insurance.

B. A group health plan, a health insurance insurer providing health insurance coverage in connection with a group health plan, or health insurance coverage offered by a health insurance insurer in the individual market shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this Section in accordance with regulations adopted by the department. This notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted:

(1) In the next mailing made by the plan or insurer to the participant or beneficiary;

(2) As part of any yearly informational packet sent to the participant or beneficiary; or

(3) Not later than January 1, 2000; whichever is earlier.

C. A group health plan, a health insurance insurer offering group health insurance coverage in connection with a group health plan, or health insurance coverage offered by a health insurance insurer in the individual market may not:

(1) Deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this Section; or

(2) Penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide monetary or nonmonetary incentives to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this Section.

D. In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement imposed pursuant to this Section shall not be treated as a termination of the collective bargaining agreement.

Acts 1999, No. 30, §1.

§250.18. Identification of health benefit plan insurer and sponsor

A. Every health insurer authorized to write health and accident policies of insurance in this state who issues an identification card, member card, insurance coverage card, or other documentation of coverage to any policy holder or health plan participant shall, in issuing such card or cards, satisfy the requirements of this Section.

B. No health insurer acting as the administrator for a health benefit plan which plan is not fully insured shall issue any identification card, membership card, insurance coverage card, or other documentation of coverage on which the name of the health insurer is prominently displayed on the face of such card or documentation. The name of the health benefit plan's sponsor shall be prominently displayed on the face of such card or documentation with an annotation that the plan's benefits are being administered by the health insurance insurer.

C. The commissioner may promulgate rules and regulations implementing the provisions of this Section.

Acts 1999, No. 32, §1.

§250.19. Protections required for victims of the crime of domestic violence

A. As used in this Section, the following terms shall be defined as follows:

(1) "Abuse" means bodily injury as a result of battery or any offense against the person as defined in the Louisiana Criminal Code, except negligent injury and defamation, when such battery or offense is committed by one family or household member against another. "Abuse" shall also mean abuse of adults as defined in R.S. 14:403.2 when committed by an adult child or adult grandchild.

(2) "Abuse status" means the fact or perception that a person is, has been, or may be a subject of abuse, irrespective of whether the person has sustained abuse-related medical conditions.

(3) "Confidential abuse information" means information about acts of abuse or the abuse status of a subject of abuse, the fact that a person's medical condition is abuse-related if the issuer knows or has reason to know it is abuse-related, the home and work address and telephone number of a subject of abuse, or the status of an applicant or insured as a family member, employer, or associate of a subject of abuse, or as a person in a relationship with a subject of abuse.

(4) "Insurance professional" means an agent, broker, adjuster, or third party administrator as defined in this Title.

(5) "Subject of abuse" means a person against whom an act of abuse has been directed; who has current or prior injuries, illnesses, or disorders that result from abuse; or who seeks, may have sought, or had reason to seek medical or psychological treatment for abuse or protection, court-ordered protection, or shelter from abuse.

B. No health insurance issuer or nonfederal governmental plan shall engage in any of the following acts or practices on the basis of the abuse status of an applicant or insured:

(1) Restricting, excluding, or limiting health benefit plan coverage solely as a result of abuse status.

(2) Adding a rate differential solely because of abuse status.

(3) Denying or limiting payment of a claim incurred by an insured, enrollee, member, subscriber, or dependent solely because the claim was incurred as a result of abuse status.

C. A spouse who is the subject of domestic abuse and who, together with any other dependents, is covered as a dependent on an individual policy or subscriber agreement naming an abusive spouse as the policyholder shall have the right to convert such individual dependent coverage to an individual policy without medical underwriting upon the judgment of divorce or judgment of legal separation from the abusive spouse. The converted policy shall be on the same policy form and shall provide the same benefits, including deductibles, coinsurance, and copayments, as the policy from which coverage is being converted. The spouse converting coverage shall thereafter have the same right to change benefits upon the anniversary date of the policy as in the policy from which coverage is being converted. The right to convert coverage shall become effective upon receipt of notice of termination of coverage under an abusive spouse's policy or subscriber agreement, only if the abused spouse gives written notice within thirty days and provides the health insurance issuer with a copy of the divorce decree or separation order.

D. No health insurance issuer, nonfederal governmental plan, or person employed by or contracting with such entities shall disclose or transfer information related to the abuse status of an applicant or insured for any purpose or to any person except:

(1) To the subject of abuse or an individual specifically designated in writing by the subject of abuse.

(2) To a health care provider for the direct provision of health care services.

(3) To a licensed physician identified and designated by the subject of abuse.

(4) When ordered by a court of competent jurisdiction or otherwise required by law.

(5) When necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship. Confidential abuse information may be disclosed only if the recipient has executed a written agreement to be bound by the prohibitions of this Section in all respects and to be subject to the enforcement of this Section by the courts of this state for the benefit of the applicant or the insured and only to the following persons:

(a) A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of abuse and that cannot underwrite or satisfy its obligations under the reinsurance agreement without that disclosure.

(b) A party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the health insurance issuer or insurance professional.

(c) Medical or claims personnel contracting with the health insurance issuer or insurance professional, but only when necessary to process an application, to perform the health insurance issuer's or the insurance professional's duties under the policy, or to protect the safety or privacy of a subject of abuse. For purposes of this Paragraph, a health insurance issuer or insurance professional shall include a parent or affiliate company of the health insurance issuer or an insurance professional who has a service agreement with the health insurance issuer or insurance professional.

(d) With respect to the address and telephone number of a subject of abuse, to entities with whom the health insurance issuer or insurance professional transacts business when the business cannot be transacted without the address and telephone number.

(6) To an attorney who needs the information to represent the health insurance issuer or insurance professional effectively only if the health insurance issuer or insurance professional notifies the attorney of its obligations under this Section and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the health insurance issuer or insurance professional.

(7) To the policyowner or assignee, in the course of delivery of the policy, if the policy contains information about abuse status.

(8) To any other entities authorized by regulations adopted by the commissioner of insurance pursuant to the Administrative Procedure Act.

E. Nothing in this Section shall prohibit a health insurance issuer or a nonfederal governmental plan from asking about a medical condition or from using medical information to underwrite or to carry out its duties under the policy, even if the medical information is related to a medical condition that the insurer or insurance professional knows or has reason to know is abuse-related, to the extent otherwise permitted under this Section and other applicable laws.

Acts 1999, No. 1185, §1.

§250.20. Compliance of health insurance issuer with Gramm-Leach-Bliley Act

A health insurance issuer who is in compliance with the privacy requirements of the federal Health Insurance Portability and Accountability Act of 1996 (42 USC 1320d) shall be deemed to be in compliance with state law intended to implement requirements of Title V of the federal Gramm-Leach-Bliley Act.

Acts 2003, No. 659, §1.

PART VI-D. STANDARDS FOR HEALTH INSURANCE COVERAGE

§250.31. Definitions

As used in this Part, the following terms shall be defined as follows:

(1) "Accepted claim" means either of the following:

(a) A nonelectronic claim on a HCFA 1500 form or Uniform Billing Form 92 (UB92), properly completed according to Medicare guidelines.

(b) An electronic claim in an 837 (ASC X12N 837) format or its successor adopted by the United States Department of Health and Human Services or its successor, in compliance with the provisions of the Health Insurance Portability and Accountability Act (42 USC 1302d et seq. and 45 C.F.R. Parts 160 and 162), that includes all of the following:

(i) Data that is required according to the United States Department of Health and Human Services standards for electronic transactions.

(ii) Data that becomes required due to the situation according to the United States Department of Health and Human Services standards for electronic transactions.

(iii) Data that is required according to notice by the health insurance issuer or its agent to the health care provider or its agent. Such data shall be as described in the Payer's Companion Guide in accordance with the United States Department of Health and Human Services standards for electronic transactions.

(2) "Claim" means a request by a health care provider for payment from a health insurance issuer.

(3) "Clean claim" means an accepted claim that has no defect or impropriety including any lack of required substantiating documentation or other particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this Part.

(4) "Correct claims address" means the address appearing on an enrollee's or insured's current identification card issued by the health insurance issuer as the current address at which claims are received, or, if no address appears on the identification card, the current address for receipt of claims provided by the health insurance issuer to the department. The department shall, as a courtesy to the health care industry, maintain a list of such current addresses on its website.

(5) "Commissioner" means the commissioner of insurance.

(6) "Department" means the Department of Insurance.

(7) "Electronic claim" means a claim submitted by a health care provider or its agent to a health insurance issuer in compliance with the provisions of the Health Insurance Portability and Accountability Act (42 USC 1302d et seq. and 45 C.F.R. Parts 160 and 162) and in a format currently adopted by the United States Department of Health and Human Services or its successor.

(8) "Enrollee" or "insured" means an individual who is enrolled or insured by a health insurance issuer for health insurance coverage.

(9) "Exception report" means an electronic communication related to an electronic claim submission of each electronic claim transaction in that submission that is not deemed an accepted claim. Such communication is sent by a health insurance issuer or a health care clearinghouse to a health care provider or a health care clearinghouse from which the electronic claim transaction was received.

(10) "Health care clearinghouse" means a public or private entity that does either of the following:

(a) Processes or facilitates the processing of information from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

(b) Receives a standard transaction from another entity and processes or facilitates the processing of information into a nonstandard format or nonstandard data content for a receiving entity.

(11) "Health care provider" or "provider" means:

(a) A physician or other health care practitioner licensed, certified, registered, or otherwise authorized to perform specified health care services consistent with state law.

(b) A facility or institution providing health care services, including but not limited to a hospital or other licensed inpatient center, ambulatory surgical or treatment center, skilled nursing facility, inpatient hospice facility, residential treatment center, diagnostic, laboratory, or imaging center, or rehabilitation or other therapeutic health setting.

(12) "Health care services" means services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(13) "Health insurance coverage" or "coverage" means benefits consisting of health care services provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as health care services under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer. However, "health insurance coverage" or "coverage " shall not include benefits due under Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950 or limited benefit and supplemental health insurance policies, benefits provided under a separate policy, certificate, or contract of insurance for accidents, disability income, limited scope dental or vision benefits, or benefits for long-term care, nursing home care, home health care, or specific diseases or illnesses.

(14) "Health insurance issuer" or "issuer" means any entity that offers health insurance coverage through a policy, contract, or certificate of insurance subject to state law that regulates the business of insurance. For purposes of this Part, a "health insurance issuer" or "issuer" shall include but not be limited to a health maintenance organization as defined and licensed pursuant to Part XII of Chapter 2 of this Title. A "health insurance issuer" or "issuer" shall not include any entity preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974.

(15) "Health insurance issuer liability" means the contractual liability of a health insurance issuer for covered health care services pursuant to the plan or policy provisions between the enrollee or insured and the health insurance issuer.

(a) In the case of a contracted health care provider, "health insurance issuer liability" is the contracted reimbursement rate reduced by the patient responsibility, which includes coinsurance, copayments, deductibles, or any other amounts identified by the health insurance issuer on an explanation of benefits as an amount for which the enrollee or insured is liable for the covered health care services.

(b) In the case of a noncontracted health care provider, or when a contracted reimbursement rate has not been established, "health insurance issuer liability" is the liability pursuant to the plan or policy provisions between a health insurance issuer and its enrollee or insured for the covered health care services.

(16) "Network of providers" or "network" means an entity, including but not limited to a preferred provider organization as defined in R.S. 40:2202(5) and (6), other than a health insurance issuer that, through contracts with health care providers, provides or arranges for access by individuals or groups of individuals eligible for health insurance coverage to health care services by health care providers who are not otherwise or individually contracted directly with a health insurance issuer.

(17) "Nonelectronic claim" means a claim submitted by a health care provider or its agent to a health insurance issuer or its agent using a HCFA 1500 form or a Uniform Billing Form 92 (UB92), as appropriate, or a successor to either of these forms adopted by the National Uniform Billing Committee or its successor.

(18) "Paid" means the transfer by the health insurance issuer or its agent of the amount of the health insurance issuer liability on either of the following dates:

(a) The date of mailing of a check via the United States Postal Service or a commercial carrier to the correct address.

(b) The date of electronic transfer of funds.

(19) "Received" or "receipt" means:

(a) For a nonelectronic claim:

(i) For a claim mailed via the United States Postal Service for which no return receipt is requested, the physical receipt of the claim by the health insurance issuer or its agent designated for the receipt of claims at the correct claims address, as documented in accordance with claims filing procedures filed by the health insurance issuer with the department.

(ii) For a claim sent via a commercial carrier or via the United States Postal Service for which return receipt is requested, the date the delivery receipt is signed by the health insurance issuer or its agent designated for the receipt of claims at the correct claims address, as documented in accordance with claims filing procedures filed by the health insurance issuer with the department.

(b) For an electronic claim, either of the following:

(i) For a claim submitted by a health care provider directly to the health insurance issuer or its agent designated for receipt of claims, the date of an electronic receipt issued by the health insurance issuer or its agent to the provider for the electronic claim or a batch of claims that includes the claim, unless the claim appears on a related exception report or was included in a batch of claims for which a batch rejection report was issued.

(ii) For a claim submitted by a health care provider to a health care clearinghouse, the date of an electronic receipt issued by the health insurance issuer or its agent to the health care clearinghouse for the electronic claim or a batch of claims that includes the claim, unless the claim appears on a related exception report or was included in a batch of claims for which a batch rejection report was issued.

(20) "Remittance advice" means a written or electronic communication explaining the issuer's action on each claim adjudicated by the issuer. Such communication is sent by a health insurance issuer or its agent to a health care provider or its agent.

(21) "Rural hospital" shall mean either:

(a) A hospital with sixty or fewer beds located in either:

(i) A parish with a population of less than fifty thousand according to the most recent federal decennial census.

(ii) A municipality with a population of less than twenty thousand according to the most recent federal decennial census.

(b) A hospital classified as a sole community hospital pursuant to 42 CFR 412.92.

Acts 1999, No. 1017, §1; Acts 2001, No. 1096, §1; Acts 2001, No. 1198, §1, eff. June 29, 2001; Acts 2005, No. 273, §1, eff. January 1, 2006.

§250.32. Standards for receipt and processing of nonelectronic claims

A.(1) Any nonelectronic claim by a health care provider under a contract with a health insurance issuer, for provision of health care services, submitted by the provider or its agent within forty-five days of the date of service, or date of discharge from a health care facility or institution, shall be paid, denied, or pended not more than forty-five days from the date upon which a nonelectronic clean claim is received by the issuer or its agent, unless it is not payable under the terms of the applicable contract of health insurance coverage or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard.

(2) Any nonelectronic claim by a health care provider under a contract with a health insurance issuer, for provision of health care services, submitted by the provider or its agent more than forty-five days after the date of service, or date of discharge from a health care facility or institution, or resubmitted because the original claim was not an accepted claim or not a clean claim shall be paid, denied, or pended not more than sixty days from the date upon which a nonelectronic clean claim is received by the issuer or its agent, unless it is not payable under the terms of the applicable contract of insurance or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard.

(3) Any other nonelectronic claim for health insurance coverage benefits submitted for payment by an enrollee or insured or by a noncontracted health care provider rendering covered health care services, or by the provider's agent, shall be paid, denied, or pended not more than forty-five days from the date upon which a nonelectronic clean claim is received by the issuer or its agent, unless it is not payable under the terms of the applicable contract of insurance or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard.

(4) For purposes of this Subsection, the issuer shall either provide written notice to the provider that a claim is pended or allow the provider Internet access to such information.

(5) Just and reasonable grounds, as used in this Subsection, shall include but not be limited to determination of whether the enrollee or insured was eligible for health insurance coverage on the date health care services were rendered.

B.(1) Health insurance issuers shall have appropriate procedures approved by the department to assure compliance with this Part. Health insurance issuers shall have appropriate handling procedures approved by the department for the acceptance of nonelectronic claim submissions. Such procedures shall include but not be limited to the following:

(a) A process for documenting the date of actual receipt of nonelectronic claims.

(b) A process for reviewing nonelectronic claims for accuracy and acceptability.

(c) A process for prevention of loss of such claims.

(2) Such procedures shall assure that all such claims received are reviewed for determination as to whether such claims are accepted or clean claims.

(3) The department may promulgate and adopt additional handling procedures consistent with this Section by rule pursuant to the Administrative Procedure Act.

C. Health insurance issuers shall establish appropriate procedures approved by the department to assure that any health care provider who is not paid within the time frames specified in this Section receives a late payment adjustment equal to twelve percent per annum of the amount due.

D. The provisions of this Part shall not apply to the Office of Group Benefits.

Acts 1999, No. 1017, §1; Acts 2001, No. 1178, §2, eff. June 29, 2001; Acts 2005, No. 273, §1, eff. January 1, 2006.

§250.33. Standards for receipt and processing of electronic claims

A.(1) A health insurance issuer shall allow a health care provider access to information in the issuer's Payer's Companion Guide, or its successor, listing issuer-specific data requirements for accepted electronic claims. Such access shall be provided through a written notice to the provider or through Internet access.

(2) Within five working days of receipt of an electronic claim, a health insurance issuer or its agent shall review the entire claim and, if the issuer determines that the claim is not an accepted claim, issue an exception report to the provider or its agent indicating all defects or reasons known at that time that the claim is not an accepted claim. A provider who submits a claim that is not an accepted claim shall be deemed to have timely submitted a claim for the payment of covered health care services if the health insurance issuer or its agent fails to notify the health care provider, or the health care clearinghouse from which the claim was received, of all defects or reasons known at that time that the claim is not an accepted claim as required by this Subsection.

(3) Such exception report shall contain at a minimum the following information, if known at that time, for each claim submitted:

(a) Patient name.

(b) Provider claim number, patient account number, or unique insured/enrollee identification number.

(c) Date of service.

(d) Total billed charges.

(e) Exception report issuer's name.

(f) The date upon which the exception report was generated.

(4) When the issuer or its agent rejects an entire batch of claims, the issuer or its agent shall send a batch rejection report to the entity from which the rejected batch of claims was received. Such batch rejection report shall contain at a minimum the following information:

(a) Date batch was received by the issuer or its agent.

(b) Date of rejection report.

(c) Name or identification number of entity issuing batch rejection report.

(d) Batch submitter's name or identification number, whichever is available.

(e) Reason batch is rejected.

B.(1) Any electronic claim shall be paid, denied, or pended not more than twenty-five days from the date upon which an electronic clean claim is electronically received by the health insurance issuer or its agent, unless it is not payable under the terms of the applicable contract of insurance or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard.

(2) For purposes of this Subsection, the issuer shall either provide written notice to the provider that a claim is pended or allow the provider Internet access to such information.

(3) Just and reasonable grounds, as used in this Subsection, shall include but not be limited to determination of whether the enrollee or insured was eligible for health insurance coverage on the date health care services were rendered.

C. Health insurance issuers shall have appropriate handling procedures approved by the department for the acceptance of electronic claim submissions. Such procedures shall include but not be limited to the following:

(1) A process for electronically recording the time and date of actual receipt of electronic claims.

(2) A process for electronic review of transmitted claims that assures all such claims received are reviewed for determination of whether such claims are deemed accepted in accordance with Subsection A of this Section.

(3) A process for reporting all claims not accepted and batches of claims rejected and all defects or reasons known at that time that such claims were not accepted or batches of claims were rejected.

D. Health insurance issuers shall establish appropriate procedures approved by the department to assure that any health care provider who is not paid within the time frame specified in this Section receives a late payment adjustment equal to twelve percent per annum of the amount due.

E. The provisions of this Part shall not apply to the Office of Group Benefits.

Acts 1999, No. 1017, §1; Acts 2001, No. 1178, §2, eff. June 29, 2001; Acts 2005, No. 273, §1, eff. January 1, 2006.

§250.34. Remittance advice; thirty-day payment standard; limitations on claim filing and audits

A. Each remittance advice generated by a health insurance issuer or its agent to a health care provider or its agent shall include the following information, if known at that time, clearly identified for each claim listed:

(1) The name of the enrollee or insured.

(2) Unique enrollee or insured identification number.

(3) Patient claim number or patient account number.

(4) Date of service.

(5) Total provider charges.

(6) Health insurance issuer contractual discount amount.

(7) Enrollee or insured liability, specifying any coinsurance, deductible, copayment, or noncovered amount.

(8) Amount paid by health insurance issuer.

(9) Amount adjusted by health insurance issuer and the reason for adjustment.

(10) Amount denied and the reason for denial.

B. A health insurance issuer may elect to utilize a thirty-day payment standard for compliance with R.S. 22:250.32 and 250.33 by providing written notice to the commissioner. Such notice shall be in a form prescribed by the commissioner and shall remain in effect until withdrawn in writing as may be required by the commissioner. Any health insurance issuer electing to utilize a thirty-day payment standard shall continue to comply with all other requirements of this Part.

C. A health insurance issuer that prescribes the period of time that a health care provider under contract for provision of health care services has to submit a claim for payment under R.S. 22:250.32 or 250.33 shall have the same prescribed period of time following payment of such claim to perform any review or audit for purposes of reconsidering the validity of such claim.

D. Notwithstanding any other provision of law to the contrary, no health insurance insurer shall limit the right of a rural hospital to receive payment for covered health care services as long as a claim for payment of such services is submitted within one year after the date on which the rural hospital provided the services.

Acts 1999, No. 1017, §1; Acts 2001, No. 1198, §1, eff. June 29, 2001; Acts 2005, No. 273, §1, eff. January 1, 2006.

§250.35. Regulations; applicability

A. The commissioner may, after notice and hearing, promulgate such rules and regulations as may be necessary or proper to carry out the provisions of this Part. Such rules and regulations shall be promulgated and adopted in accordance with the Administrative Procedure Act.

B. A health insurance issuer that contracts, subcontracts, or arranges with another entity for the provision of any services related to payment of claims, including but not limited to a third-party administrator or a network of providers, shall be responsible for compliance with all provisions of this Part.

C. The provisions of this Part shall not supersede the provisions of Part VI-F of this Chapter.

Acts 1999, No. 1017, §1; Acts 2005, No. 273, §1, eff. January 1, 2006.

§250.36. Coordination of benefits

A. Coordination of benefit requirements adopted by health insurance issuers shall, at a minimum, adhere to the following requirements:

(1) No plan shall contain a provision that its benefits are "always excess" or "always secondary" except in accordance with rules adopted by the commissioner pursuant to this Part.

(2) A coordination of benefit provision may not be used that permits a plan to reduce its benefits on the basis of any of the following:

(a) That another plan exists and the covered person did not enroll in the plan.

(b) That a person is or could have been covered under another plan, except with respect to Part B of Medicare.

(c) That a person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

B. The commissioner shall be authorized to adopt such reasonable regulations as necessary for determining the order of benefit payments when a person is covered by two or more plans of health insurance coverage.

Acts 1999, No. 1017, §1, eff. July 9, 1999.

§250.37. Violations; cease and desist orders; penalties

A. Whenever the commissioner has reason to believe that any health insurance issuer is not in full compliance with the requirements of this Part, he shall notify such issuer and, after notice and opportunity for hearing pursuant to Part XXIX of this Chapter, subject to Chapter 13-B of Title 49 of the Louisiana Revised Statutes of 1950, the commissioner shall issue and cause to be served an order requiring the health insurance issuer to cease and desist from any violation and order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each and every act or violation, not to exceed an aggregate penalty of one hundred thousand dollars. However, if the health insurance issuer knew or reasonably should have known that it was in violation of this Part, the penalty shall be not more than twenty-five thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of two hundred fifty thousand dollars in any six-month period.

(2) Suspension or revocation of the certificate of authority of the health insurance issuer to operate in this state if it knew or reasonably should have known it was in violation of this Part. However, notice of any such violation by the Office of Group Benefits shall be submitted to the governor and the chairmen of the House Committee on Appropriations and the Senate Committee on Finance.

B. Any health insurance issuer who violates a cease and desist order issued by the commissioner pursuant to this Section while such order is in effect shall, after notice and opportunity for hearing, be subject at the discretion of the commissioner to any one or more of the following:

(1) A monetary penalty of not more than twenty-five thousand dollars for each and every act or violation, not to exceed an aggregate of two hundred fifty thousand dollars.

(2) Suspension or revocation of the certificate of authority of the health insurance issuer to operate in this state. However, notice of any such violation by the Office of Group Benefits shall be submitted to the governor and the chairmen of the House Committee on Appropriations and the Senate Committee on Finance.

Acts 1999, No. 1017, §1, eff. July 9, 1999; Acts 2001, No. 1178, §2, eff. June 29, 2001.

§250.38. Recoupment of health insurance claims payments

A. As used in this Section, "recoupment" shall mean a reduction, offset, adjustment, or other act to lower or lessen the payment of a claim or any other amount owed to a health care provider for any reason unrelated to that claim or other amount owed to a health care provider.

B. Prior to any recoupment unrelated to a claim for payment of medical services provided by a health care provider or any other amount owed by a health insurance issuer to a health care provider, the health insurance issuer shall provide the health care provider written notification that includes the name of the patient, the date or dates of health care services rendered, and an explanation of the reason for recoupment. A health care provider shall be allowed thirty days from receipt of written notification of recoupment to appeal the health insurance issuer's action and to provide the health insurance issuer the name of the patient, the date or dates of health care services rendered, and an explanation of the reason for the appeal.

C.(1) When a health care provider fails to respond timely and in writing to a health insurance issuer's written notification of recoupment, the health insurance issuer may consider the recoupment accepted.

(2) If a recoupment is accepted, the health care provider may remit the agreed amount to the health insurance issuer at the time of any written notification of acceptance or may permit the health insurance issuer to deduct the agreed amount from future payments due to the health care provider.

D.(1) If a health care provider disputes a health insurance issuer's written notification of recoupment and a contract exists between the health care provider and the health insurance issuer, the dispute shall be resolved according to the general dispute resolution provisions in the contract.

(2) If a health care provider disputes a health insurance issuer's written notification of recoupment and no contract exists between the health care provider and the health insurance issuer, the dispute shall be resolved as any other dispute under Civil Code Article 2299 et seq.

E. If the recoupment directly affects the payment responsibility of the insured, the health insurance issuer shall provide at the same time a revised explanation of benefits to the health care provider and the covered person for whose claim the recoupment is being made. Unless the recoupment of a health insurance claim payment directly affects the payment responsibility of the insured, such recoupment shall not result in any increased liability of an insured.

F. The provisions of this Section shall not apply to the Office of Group Benefits.

Acts 2001, No. 1096, §1; Acts 2003, No. 672, §1.

PART VI-E. HEALTH CARE CONSUMER BILLING AND DISCLOSURE PROTECTION ACT

§250.41. Short title

This Part shall be known and may be cited as the "Health Care Consumer Billing and Disclosure Protection Act".

Acts 2003, No. 1157, §1, eff. Jan. 1, 2004.

§250.42. Definitions

As used in this Part:

(1) "Activity statement" means any written communication from a health care provider that advises an enrollee or insured of covered health care services that have been billed to a health insurance issuer.

(2) "Base health care facility" means a facility or institution providing health care services, including but not limited to a hospital or other licensed inpatient center, ambulatory surgical or treatment center, skilled nursing facility, inpatient hospice facility, residential treatment center, diagnostic, laboratory, or imaging center, or rehabilitation or other therapeutic health setting that has entered into a contract or agreement with a facility-based physician. Pursuant to such contract or agreement, the facility-based physician agrees to provide required health care services to those enrollees or insureds presenting at such facility, within the scope of the physician's respective specialty.

(3) "Bill" means any written or electronic communication that sets forth the amount owed by an enrollee or insured.

(4) "Commissioner" means the commissioner of insurance.

(5) "Consolidated activity statement and bill" means any written or electronic communication from a health care provider that advises an enrollee or insured of covered health care services that have been billed to a health insurance issuer and which sets forth an amount owed by an enrollee or insured.

(6) "Contracted health care provider" means a health care provider that has entered into a contract or agreement directly with a health insurance issuer or with a health insurance issuer through a network of providers for the provision of covered health care services.

(7) "Contracted reimbursement rate" means the aggregate maximum amount that a contracted health care provider has agreed to accept from all sources for provision of covered health care services under the health insurance coverage applicable to the enrollee or insured.

(8) "Covered health care services" means services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease that are either covered and payable under the terms of health insurance coverage or required by law to be covered.

(9) "Discount billing" means any written or electronic communication issued by a contracted health care provider that appears to attempt to collect from an enrollee or insured an amount in excess of the contracted reimbursement rate for covered services.

(10) "Dual billing" means any written or electronic communication issued by a contracted health care provider that sets forth any amount owed by an enrollee or insured that is a health insurance issuer liability.

(11) "Enrollee" or "insured" means a person who is enrolled in or insured by a health insurance issuer for health insurance coverage.

(12) "Explanation of benefits" means any written communication clearly identified as issued by the health insurance issuer or its agent that contains information regarding coverage, payment, or other information regarding current status of a claim submitted to the health insurance issuer or its agent.

(13) "Facility-based physician" means a physician licensed to practice medicine who is required by the base health facility to provide services in a base health care facility as an anesthesiologist, hospitalist, intensivist, neonatologist, pathologist, radiologist, emergency room physician, or other on-call physician who is required by the base health care to provide covered health care services related to an emergency medical condition as defined in R.S. 22:3071.

(14) "Health care facility" means a facility or institution providing health care services including but not limited to a hospital or other licensed inpatient center, ambulatory surgical or treatment center, skilled nursing facility, inpatient hospice facility, residential treatment center, diagnostic, laboratory, or imaging center, or rehabilitation or other therapeutic health setting. A health care facility may also be a base health care facility.

(15) "Health care professional" means a physician or other health care practitioner licensed, certified, or registered to perform specified health care services consistent with state law.

(16) "Health care provider" or "provider" means a health care professional or a health care facility or the agent or assignee of such professional or facility.

(17) "Health care services" means services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(18) "Health insurance coverage" means benefits consisting of medical care provided or arranged for directly, through insurance or reimbursement, or otherwise, and includes health care services paid for under any plan, policy, or certificate of insurance.

(19) "Health insurance issuer" means any entity that offers health insurance coverage through a policy or certificate of insurance subject to state law that regulates the business of insurance. For purposes of this Part, a "health insurance issuer" shall include a health maintenance organization, as defined and licensed pursuant to Part XII of Chapter II of this Title, nonfederal government plans subject to the provisions of Part VI-D of this Chapter, and the Office of Group Benefits.

(20)(a) "Health insurance issuer liability" means the contractual liability of a health insurance issuer for covered health care services pursuant to the plan or policy provisions between the enrollee or insured and the health insurance issuer.

(b) In the case of a contracted health care provider, "health insurance issuer liability" is the contracted reimbursement rate reduced by the patient responsibility, which includes coinsurance, copayments, deductibles, or any other amounts identified by the health insurance issuer on an explanation of benefits as an amount for which the enrollee or insured is liable for the covered service.

(c) In the case in which a contracted reimbursement rate has not been established, "health insurance issuer liability" is the liability pursuant to the plan or policy provisions between a health insurance issuer and their enrollee or insured for the covered service.

(d) In the case of noncontracted facility-based physicians providing covered health care services at a base health care facility, "health insurance insurer liability" is the amount as determined pursuant to the plan or policy provisions between the enrollee or insured and the health insurance issuer.

(21) "Network of providers" or "network" means an entity other than a health insurance issuer that, through contracts with health care providers, provides or arranges for access by groups of enrollees or insureds to health care services by health care providers who are not otherwise or individually contracted directly with a health insurance issuer.

(22) "Noncontracted health care provider" means a health care provider that has not entered into a contract or agreement with a health insurance issuer or network of providers for the provision of covered health care services.

(23) "Noncovered health care services" means services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease that are neither covered under the terms of health insurance coverage nor required by law to be covered.

Acts 2003, No. 1157, §1, eff. Jan. 1, 2004.

§250.43. Notice requirements

A. Provider notice requirements shall be as follows:

(1)(a) Any activity statement received by an enrollee or insured from a contracted health care provider shall clearly delineate the amount billed to the health insurance issuer for covered health care services and shall contain the following language conspicuously displayed on the front of such activity statement in at least twelve-point boldface capital letters:

"NOTICE:
THIS IS NOT A BILL. DO NOT PAY. IF IT IS DETERMINED THAT THIS SERVICE OR A PORTION OF THESE SERVICES IS NOT PAYABLE BY YOUR HEALTH PLAN, YOU WILL BE RESPONSIBLE."

(b) A provider may revise or update any activity statement to the enrollee or insured based on the status of the health insurance issuer's liability.

(2) Any bill received by an enrollee or insured from a contracted health care provider shall clearly delineate the amount that is owed by the enrollee or insured, based on the contracted reimbursement rate, and shall contain the following language conspicuously displayed on the front of such bill in at least twelve-point boldface capital letters:

"NOTICE:
THIS IS A BILL. BASED UPON INFORMATION FROM YOUR HEALTH PLAN, YOU OWE THE AMOUNT SHOWN."

(3) Any consolidated activity statement and bill received by an enrollee or insured from a contracted health care provider shall clearly delineate the amount owed by the enrollee or insured and the amount billed to the health insurance issuer. A consolidated activity statement and bill shall comply with Paragraph (2) of this Subsection.

(4) In the event that any overstatement in the amount owed by the enrollee or insured in any bill or in any consolidated activity statement and bill is based on information received from a health insurance issuer, the contracted health care provider shall not be in violation of this Part.

(5) Any written or electronic notice, publication, or document issued by or on behalf of a health care facility that identifies any health insurance issuer or network of providers with which the health care facility is a contracted health care provider shall state that facility-based physicians providing health care services at the facility may not be contracted health care providers. The facility shall make specific information on contracted or noncontracted physicians available on request from an enrollee or insured.

B. Health insurance issuer notice requirements shall be as follows:

(1) Each health insurance identification card issued by a health insurance issuer shall contain sufficient information to clearly identify the health insurance issuer.

(2) Each policy, certificate of insurance, and health insurance identification card issued by a health insurance issuer shall contain or be accompanied by the following notice to enrollees or insureds:

"NOTICE:
YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES."

(3) Any written or electronic notice, publication, or document issued by or on behalf of a health insurance issuer or through a network of providers to an enrollee or insured that identifies contracted health care providers shall state that facility-based physicians may not be contracted health care providers. The health insurance issuer shall make specific information on contracted and noncontracted facility-based physicians available on request from an enrollee or insured.

(4) A health insurance issuer shall update its list of contracted health care providers on at least an annual basis and shall make the current version available to enrollees or insureds on request.

(5) In the event that a health insurance issuer determines that any amount due a health care provider is the responsibility of the enrollee or insured, the health insurance issuer shall specifically set forth, in its explanation of benefits, the contracted reimbursement rate and clearly identify the amount due from the enrollee or insured and the reasons therefor. The health insurance issuer shall determine the responsibility of the enrollee or insured based on the contracted reimbursement rate.

(6) To the extent that a health insurance issuer determines that additional information is needed for payment, the health insurance issuer shall notify the health care provider and the enrollee or insured in writing regarding the information needed and identify the party responsible for furnishing such information. In the event that the enrollee or insured is the party responsible for providing such additional information and the enrollee or insured does not provide the requested information to the health insurance issuer within forty-five days from the date of such notification, the health care provider may bill the enrollee or insured for services at the contracted reimbursement rate when a contract exists.

C. If the patient approves in advance and in writing the charges for which the patient will be responsible, nothing in this Section shall be construed to prevent a dental patient from choosing any type, form, or quality of dental procedure that is a noncovered health care service.

Added by Acts 2003, No. 1157, §1, eff. January 1, 2004; Acts 2004, No. 607, §1.

§250.44. Billing by contracted health care providers

A.(1) A contracted health care provider shall be prohibited from discount billing, dual billing, attempting to collect from, or collecting from an enrollee or insured a health insurance issuer liability or any amount in excess of the contracted reimbursement rate for covered health care services.

(2) No contracted health care provider shall bill, attempt to collect from, or collect from an enrollee or insured any amounts other than those representing coinsurance, copayments, deductibles, noncovered or noncontracted health care services, or other amounts identified by the health insurance issuer on an explanation of benefits as an amount for which the enrollee or insured is liable.

(3) However, in the event that any billing, attempt to collect from, or the collection from an enrollee or insured of any amount other than those representing copayment, deductible, coinsurance, payment for noncovered or noncontracted health care services, or other amounts identified by the health insurance issuer as the liability of the enrollee or insured is based on information received from a health insurance issuer, the contracted health care provider shall not be in violation of this Subsection.

(4) A health insurance issuer contracting with a network of providers is obligated to pay to a contracted health care provider the contracted reimbursement rate of the network identified on the member identification card of the enrollee or insured, pursuant to R.S. 40:2203.1, and established by the contract between the network of providers and the contracted health care provider. The payor must comply with all provisions of the specific network contract. To the extent that a health insurance issuer does not pay to the health care provider an amount equal to the health insurance issuer liability, the contracted health care provider may collect the difference between the amount paid by the health insurance issuer and the health insurance issuer liability from the enrollee or insured. Any such collection efforts shall not constitute a violation of this Part.

B. No contracted health care provider may maintain any action at law against an enrollee or insured for a health insurance issuer liability or for payment of any amount in excess of the contracted reimbursement rate for such services. In the event of such an action, the prevailing party shall be entitled to recover all costs incurred, including reasonable attorney fees and court costs. However, nothing in this Subsection shall be construed to prohibit a contracted health care provider from maintaining any action at law against an enrollee or insured after a health insurance issuer determines that the health insurance issuer is not liable for the health care services rendered.

Acts 2003, No. 1157, §1, eff. Jan. 1, 2004.

§250.45. Billing by noncontracted facility-based physicians providing services in a base health care facility

If a facility-based physician who is a noncontracted health care provider provides health care services in a base health care facility to an enrollee or insured and files a claim with a health insurance issuer for such facility-based services, the health insurance issuer shall provide the facility-based physician with an explanation of benefits as to any payment determination thereof. Nothing contained herein shall supersede the provisions of R.S. 22:2018(D).

Acts 2003, No. 1157, §1, eff. Jan. 1, 2004.

§250.46. Correction of credit records

Any contracted health care provider who files, refers, or sends a report to a credit reporting agency for nonpayment by an enrollee or insured of any amount that he is prohibited by R.S. 22:250.44(A) from billing or collecting shall assist in correcting the credit record of the enrollee or insured by providing a letter to the credit reporting agency and to the enrollee or insured. Such letter shall state that such amount is not due from the enrollee or insured to the contracted health care provider. If such letter is not sent within ten days of receipt of written notice from the enrollee or insured, the health insurance issuer, or the commissioner, the contracted health care provider shall be liable for all reasonable costs, including reasonable attorney fees and court costs, incurred by the enrollee or insured with correcting such erroneous credit record.

Acts 2003, No. 1157, §1, eff. Jan.1, 2004.

§250.47. Complaint notice; billing correction and refund; penalty

A.(1) Any enrollee or insured who receives a bill or consolidated activity statement and bill from a contracted health care provider in violation of R.S. 22:250.44(A), or a health insurance issuer acting on behalf of an enrollee or insured, may file a complaint with the Consumer Protection Division of the Department of Justice.

(2) The enrollee or insured, or health insurance issuer acting on behalf of the enrollee or insured, shall provide to the attorney general a copy of the original bill or consolidated activity statement and bill issued pursuant to R.S. 22:250.43 and such additional information that may be requested by the attorney general, documenting an attempt by a contracted health care provider to collect or the collection of any amount from the enrollee or insured that is the liability of the health insurance issuer or that is in excess of the contracted reimbursement rate. In the event it is determined that billing activity was based on information received from the health insurance issuer, the contracted health care provider shall not be in violation, and the attorney general shall refer the violation to the commissioner.

(3) If the attorney general concludes, based on the information submitted, that a contracted health care provider has attempted to collect, or collected, any amount from the enrollee or insured that is the liability of the health insurance issuer or that is in excess of the contracted reimbursement rate, the attorney general may pursue remedies as provided for in R.S. 51:1401 et seq., beginning with a notice of unfair trade practices.

(4) Any contracted health care provider who has demanded or received payment from an enrollee or insured for any amount which he is prohibited from billing or collecting by R.S. 22:250.44(A) shall correct his billing and refund any such amount paid within forty-five days of service of the notice of unfair trade practices.

(5) The notice of unfair trade practices shall be satisfied by the attorney general within thirty days of receipt of information from the contracted health care provider that shows that any such billing or collection efforts were not in violation of R.S. 22:250.44(A).

(6) In the event that a contracted health care provider fails to comply with a notice of unfair trade practices, the attorney general may proceed in accordance with the Unfair Trade Practices and Consumer Protection Law, R.S. 51:1401 et seq.

B.(1) Any enrollee or insured or contracted health care provider or noncontracted facility-based physicians providing services in a base health care facility who identifies that a health insurance issuer is in violation of R.S. 22:250.41 through 250.46 shall be entitled to request a cease and desist order from the commissioner of insurance as provided in this Subsection.

(2) The enrollee, insured, contracted health care provider, or noncontracted facility-based physicians providing services in a base health care facility shall provide to the commissioner documentation of such violation.

(3) If the commissioner concludes, based on the information submitted, that a health insurance issuer has violated this Section, the commissioner shall, within sixty days of receipt of such information, issue to such health insurance issuer a written order directing the health insurance issuer to cease and desist such violation.

(4) Any health insurance issuer shall correct such violation within forty-five days of service of the cease and desist order issued by the commissioner.

(5) The cease and desist order shall be rescinded by the commissioner within ten days of receipt of information from the health insurance issuer that it was not in violation.

(6) In the event that a health insurance issuer fails to comply with the cease and desist order issued by the commissioner, the commissioner may subsequently subject the health insurance issuer to a fine of fifty percent of any amount in violation of R.S. 22:250.45 up to a maximum fine of one thousand dollars per claim, or for such violations not related to a reimbursement amount, a fine of one thousand dollars per violation.

C. The commissioner shall not be authorized to issue a cease and desist order or to levy a fine against the Office of Group Benefits. If the commissioner concludes, based on the information submitted, that the Office of Group Benefits has violated this Section, the commissioner shall, within sixty days of receipt of such information, notify the commissioner of administration in writing.

Acts 2003, No. 1157, §1, eff. Jan. 1, 2004.

§250.48. Exception

Regardless of any contractual provisions contained in a health insurance contract or plan delivered in this state, should a patient receive a dental diagnosis from a contracted provider for which the patient qualifies for a covered dental service pursuant to the patient's health plan, the patient may choose either of the following:

(1) The covered service designated by the patient's health or dental plan for treatment of the condition diagnosed.

(2) An alternate type, form, or quality of a dental procedure to treat the diagnosed condition which procedure is of equal or greater price, provided that the patient approves the alternate procedure in advance and in writing. For alternate services or procedures provided pursuant to this Subsection, the provider shall be paid for the dental procedure as follows:

(a) The insurer shall pay the amount due for the covered procedure which was an approved service for the treatment of the diagnosed condition.

(b) The patient shall pay that amount which is the difference between the amount of the covered service and the amount of the chosen alternate service or procedure.

Added by Acts 2004, No. 607, §1.

PART VI-F. STANDARDS FOR PHARMACY AND PHARMACIST CLAIMS

§250.51. Legislative intent

The legislature finds that making prompt and correct payment for prescription drugs, other products and supplies, and pharmacist services covered under insurance or other contracts that provide for pharmacy benefits is important to the health and welfare of its citizens. It is the intent of the legislature that payments for covered prescription drugs, other products and supplies, and pharmacist services provided by pharmacists and pharmacies be paid timely and based on payment calculations that reflect nationally recognized pricing references such as average wholesale price (AWP) and maximum allowable cost (MAC). It is the intent of the legislature that the provisions of this Part shall be interpreted to achieve these ends.

Added by Acts 2004, No. 876, §1, eff. January 1, 2005.

§250.52. Definitions

As used in this Part, the following terms shall be defined as follows:

(1) "Commissioner" means the commissioner of insurance.

(2) "Department" means the Department of Insurance.

(3) "Electronic claim" means the transmission of data for purposes of payment of covered prescription drugs, other products and supplies, and pharmacist services in an electronic data format specified by a health insurance issuer and approved by the department.

(4) "Health insurance coverage" means benefits consisting of prescription drugs, other products and supplies, and pharmacist services provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as prescription drugs, other products and supplies, and pharmacist services under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer. However, "health insurance coverage" shall not include benefits due under Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950.

(5) "Health insurance issuer" means an insurance company, including a health maintenance organization as defined and licensed pursuant to Part XII of Chapter 2 of this Title, unless preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974. For purposes of this Part, a "health insurance issuer" shall include the Office of Group Benefits.

(6) "Pharmacist" means an individual currently licensed as a pharmacist by the Louisiana Board of Pharmacy to engage in the practice of pharmacy in this state.

(7) "Pharmacist services" means the filling and dispensing of prescription drugs or providing products and supplies, drug therapy, and other patient care services provided by a licensed pharmacist with the intent of achieving outcomes related to the cure, prevention, or management of a disease, elimination or reduction of patient's symptoms, or arresting or slowing of a disease process.

(8) "Pharmacy" or "pharmacies" means any appropriately licensed place within this state where prescription drugs are dispensed and pharmacist services are provided and any place outside of this state where prescription drugs are dispensed and pharmacist services are provided to residents of this state.

(9) "Uniform claim form" shall mean a form prescribed by rule by the department pursuant to R.S. 22:11.

Added by Acts 2004, No. 876, §1, eff. January 1, 2005; Acts 2005, No. 209, §1, eff. July 1, 2005.

§250.53. Nonelectronic claims submission

A.(1) Any nonelectronic claim for payment for prescription drugs, other products and supplies, and pharmacist services submitted by a pharmacist or pharmacy within forty-five days of the date of service under a contract for provision of covered benefits with a health insurance issuer shall be paid not more than forty-five days from the date upon which a correctly completed uniform claim form is furnished, unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard.

(2) Any nonelectronic claim for payment for prescription drugs, other products and supplies, and pharmacist services submitted by a pharmacist or pharmacy under a contract for provision of covered benefits with a health insurance issuer more than forty-five days after the date of service or resubmitted because the original claim was incomplete shall be paid not more than sixty days from the date upon which a correctly completed uniform claim form is furnished, unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard.

(3) Any other nonelectronic claim for payment for prescription drugs, other products and supplies, and pharmacist services, whether submitted for payment by an insured or enrollee or submitted by a pharmacist or pharmacy rendering covered services that are not otherwise payable to the pharmacist or pharmacy under contract with the health insurance issuer, shall be paid not more than thirty days from the date upon which a correctly completed uniform claim form is furnished to the health insurance issuer, unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard.

B.(1) Health insurance issuers shall have appropriate handling procedures approved by the department for the acceptance of nonelectronic claim submissions. Such procedures shall include:

(a) A process for documenting the date of actual receipt of nonelectronic claims.

(b) A process for reviewing nonelectronic claims for accuracy and acceptability.

(2) Such procedures shall assure that all such nonelectronic claims received are reviewed for correct completion within a reasonable period of time.

(3) For any nonelectronic claim that is found to be incomplete or otherwise not payable, the health insurance issuer shall provide written notice of the reasons that the claim cannot be processed for payment within two business days from the date of reviewing such claim for completion.

C. Health insurance issuers shall establish appropriate procedures approved by the department to assure that any claimant who is not paid within the time frames specified in this Section receives a late payment adjustment equal to one percent of the amount due. For any period greater than twenty-five days following the time frames specified in this Section, the health insurance issuer shall pay an additional late payment adjustment equal to one percent of the unpaid balance due for each month or partial month that such claim remains unpaid.

D. Health insurance issuers shall have appropriate procedures approved by the department to assure compliance with this Part. Such procedures shall include but shall not be limited to a plan for the acceptance of nonelectronic claim submissions to document the actual date of receipt and to prevent the loss of such claims.

Added by Acts 2004, No. 876, §1, eff. January 1, 2005.

§250.54. Electronic claim submission standards

A. Any claim for payment for covered prescription drugs, other products and supplies, and pharmacist services submitted by a pharmacist or pharmacy to a health insurance issuer as an electronic claim that is electronically adjudicated shall be paid not later than the fifteenth day after the date on which the claim was electronically adjudicated. If the governor declares a state of emergency pursuant to R.S. 29:724, the time period prescribed in this Subsection shall be interrupted during the continuance of the state of emergency for any claims office which is located in the territorial limits of the declared state of emergency.

B. Health insurance issuers shall have appropriate handling procedures approved by the department for the acceptance of electronic claim submissions. Such procedures shall include:

(1) A process for electronically dating the time and date of actual receipt of electronic claims.

(2) A process for reviewing electronic review of transmitted claims for accuracy and acceptability.

(3) A process for reporting all claims rejected during electronic transmission and the reason for the rejection.

C. Health insurance issuers shall establish appropriate procedures approved by the department to assure that any claimant who is not paid within the time frame specified in this Section receives a late payment adjustment equal to one percent of the amount due. For any period greater than twenty-five days following the time frames specified in this Section, the health insurance issuer shall pay an additional late payment adjustment equal to one percent of the unpaid balance due for each month or partial month that such claim remains unpaid.

Added by Acts 2004, No. 876, §1, eff. January 1, 2005; Acts 2005, No. 209, §1, eff. July 1, 2005.

§250.55. Submission to health insurance issuer

A. For purposes of R.S. 22:250.53, a claim shall be deemed to be submitted to the health insurance issuer when a nonelectronic claim is furnished to the health insurance issuer, its agent, or any other party that makes payment directly to the pharmacy or pharmacist, or the insured or enrollee, for the prescription drugs, other products and supplies, and pharmacist services identified on the nonelectronic claim.

B. For purposes of R.S. 22:250.54, a claim shall be deemed to be submitted to a health insurance issuer when it is electronically submitted to the health insurance issuer, its agent, or any other party that makes payment directly to the pharmacy or pharmacist for the prescription drugs, other products and supplies, and pharmacist services identified on the electronic claim.

Added by Acts 2004, No. 876, §1, eff. January 1, 2005.

§250.56. Thirty-day payment standard; limitations on claim filing and audits

A. A health insurance issuer may elect to utilize a thirty-day payment standard for compliance with R.S. 22:250.53 by providing written notice to the commissioner. Such notice shall be in a form prescribed by the commissioner and shall remain in effect until withdrawn in writing as may be required by the commissioner. Any health insurance issuer electing to utilize a thirty-day payment standard shall continue to meet all other requirements of this Part.

B. Health insurance issuers that limit the period of time that a pharmacist or pharmacy under contract for delivery of covered benefits has to submit claims for payment under R.S. 22:250.53 or 250.54 shall have the same limited period of time following payment of such claims to perform any review or audit for purposes of reconsidering the validity of such claims.

Added by Acts 2004, No. 876, §1, eff. January 1, 2005.

§250.57. Prescription drugs, products, and supplies; use of index

A. Reimbursement under a contract to a pharmacist or pharmacy for prescription drugs and other products and supplies that is calculated according to a formula that uses a nationally recognized reference in the pricing calculation shall use the most current nationally recognized reference price or amount in the actual or constructive possession of the health insurance issuer, its agent, or any other party responsible for reimbursement for prescription drugs and other products and supplies on the date of service shown on the claim.

B. Health insurance issuers, their agents, and other parties responsible for reimbursement for prescription drugs and other products and supplies shall be required to update the nationally recognized reference prices or amounts used for calculation of reimbursement for prescription drugs and other products and supplies no less than every three business days.

C. Any health insurance issuer, agent, or other party responsible for reimbursement for prescription drugs and other products and supplies that does not comply with the requirements of Subsection A or B of this Section shall be subject to the late payment adjustment provisions of R.S. 22:250.54(C) to the extent of any amount not paid in accordance with the requirements of this Section.

Added by Acts 2004, No. 876, §1, eff. January 1, 2005; Acts 2005, No. 209, §1, eff. July 1, 2005.

§250.58. Coordination of benefits

A. Coordination of benefit requirements adopted by health insurance issuers shall, at a minimum, adhere to the following requirements:

(1) No plan shall contain a provision that its benefits are "always excess" or "always secondary" except in accordance with rules adopted by the commissioner pursuant to this Part.

(2) A coordination of benefit provision may not be used that permits a plan to reduce its benefits on the basis of any of the following:

(a) That another plan exists and the covered person did not enroll in the plan.

(b) That a person is or could have been covered under another plan, except with respect to Part B of Medicare.

(c) That a person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

B. The commissioner shall be authorized to adopt such reasonable regulations as necessary for determining the order of benefit payments when a person is covered by two or more plans of health insurance coverage.

Added by Acts 2004, No. 876, §1, eff. January 1, 2005.

§250.59. Recoupment of health insurance claims payments

A. As used in this Section, "recoupment" shall mean a reduction, offset, adjustment, or other act to lower or lessen the payment of a claim or any other amount owed to a pharmacy or pharmacist for any reason unrelated to that claim or other amount owed to a pharmacy or pharmacist.

B. Prior to any recoupment unrelated to a claim for payment of prescription drugs, other products and supplies, and pharmacist services provided by a pharmacy or pharmacist or any other amount owed by a health insurance issuer to a pharmacy or pharmacist, the health insurance issuer shall provide the pharmacy or pharmacist written notification that includes the name of the patient, the date or dates of provision of prescription drugs, other products and supplies, and pharmacist services, and an explanation of the reason for recoupment. A pharmacy or pharmacist shall be allowed thirty days from receipt of written notification of recoupment to appeal the health insurance issuer's action and to provide the health insurance issuer the name of the patient, the date or dates of provision of prescription drugs, other products and supplies, pharmacist services, and an explanation of the reason for the appeal.

C.(1) When a pharmacy or pharmacist fails to respond timely and in writing to a health insurance issuer's written notification of recoupment, the health insurance issuer may consider the recoupment accepted.

(2) If a recoupment is accepted, the pharmacy or pharmacist may remit the agreed amount to the health insurance issuer at the time of any written notification of acceptance or may permit the health insurance issuer to deduct the agreed amount from future payments due to the pharmacy or pharmacist.

D.(1) If a pharmacy or pharmacist disputes a health insurance issuer's written notification of recoupment and a contract exists between the pharmacy or pharmacist and the health insurance issuer, the dispute shall be resolved according to the general dispute resolution provisions in the contract.

(2) If a pharmacy or pharmacist disputes a health insurance issuer's written notification of recoupment and no contract exists between the pharmacy or pharmacist and the health insurance issuer, the dispute shall be resolved as any other dispute under Civil Code Article 2299 et seq.

E. If the recoupment directly affects the payment responsibility of the insured, the health insurance issuer shall provide at the same time a revised explanation of benefits to the pharmacy or pharmacist and the covered person for whose claim the recoupment is being made. Unless the recoupment of a health insurance claim payment directly affects the payment responsibility of the insured, such recoupment shall not result in any increased liability of an insured.

F. For purposes of this Section, a health insurance issuer shall include, in addition to the health insurance issuer, its agent or any other party that makes payment directly to a pharmacy or pharmacist for prescription drugs, other products and supplies, and pharmacist services identified on a claim.

Added by Acts 2004, No. 876, §1, eff. January 1, 2005.

§250.60. Violations; cease and desist orders; penalties

A. Whenever the commissioner has reason to believe that any health insurance issuer is not in full compliance with the requirements of this Part, he shall notify such issuer and, after notice and opportunity for hearing pursuant to Part XXIX of this Chapter, subject to Chapter 13-B of Title 49 of the Louisiana Revised Statutes of 1950, the commissioner shall issue and cause to be served an order requiring the health insurance issuer to cease and desist from any violation and order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each and every act or violation, not to exceed an aggregate penalty of one hundred thousand dollars. However, if the health insurance issuer knew or reasonably should have known that it was in violation of this Part, the penalty shall be not more than twenty-five thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of two hundred fifty thousand dollars in any six-month period.

(2) Suspension or revocation of the certificate of authority of the health insurance issuer to operate in this state if it knew or reasonably should have known it was in violation of this Part. However, notice of any such violation by the Office of Group Benefits shall be submitted to the governor and the chairmen of the House Committee on Appropriations and the Senate Committee on Finance.

B. Any health insurance issuer who violates a cease and desist order issued by the commissioner pursuant to this Section while such order is in effect shall, after notice and opportunity for hearing, be subject at the discretion of the commissioner to any one or more of the following:

(1) A monetary penalty of not more than twenty-five thousand dollars for each and every act or violation, not to exceed an aggregate of two hundred fifty thousand dollars.

(2) Suspension or revocation of the certificate of authority of the health insurance issuer to operate in this state. However, notice of any such violation by the Office of Group Benefits shall be submitted to the governor and the chairmen of the House Committee on Appropriations and the Senate Committee on Finance.

Added by Acts 2004, No. 876, §1, eff. January 1, 2005; Acts 2005, No. 209, §1, eff. July 1, 2005.

§250.61. Regulations

The commissioner may promulgate such rules and regulations as may be necessary or proper to carry out the provisions of this Part. Such rules and regulations shall be promulgated and adopted in accordance with the Administrative Procedure Act.

Added by Acts 2004, No. 876, §1, eff. January 1, 2005.

§250.62. Applicability

The provisions of Part VI-D of this Chapter, R.S. 22:250.31 et seq., shall not apply to this Part.

Added by Acts 2004, No. 876, §1, eff. January 1, 2005.

PART VII. INDUSTRIAL INSURERS

§251. Industrial insurance defined

Industrial life insurance is hereby defined and shall be construed to be that insurance which is issued by a (1) domestic life insurance company, qualified as an industrial insurer, or (2) a life insurer, domestic or foreign, whose policies provide any or all of the benefits enumerated in R.S. 22:252, and whose policies shall not exceed the limitation set forth therein and whose policy provisions and nonforfeiture benefits are at least as favorable to the policyholder as those contained in R.S. 22:259, and R.S. 22:256, respectively.

Acts 1958, No. 125. Amended by Acts 1958, No. 94, §2, eff. Jan. 1, 1959 at 12:00 Noon.

§252. Limitations

A. No domestic industrial insurer whose capital, surplus, and deposit or whose minimum initial surplus and deposit is less than that required by R.S. 22:71 or 121 shall issue any policy or contract, or combination of policies or contracts, on a single life, in excess of the following limitations:

(1) A life insurance policy, including funeral benefits, in the aggregate value of two thousand five hundred dollars in death benefits, exclusive of multiple indemnity benefits.

(2) A disability policy in the aggregate benefits of $40.00 per week.

(3) A policy providing benefits for dismembered and broken limbs, and/or loss of eyesight in the aggregate of $1,000.00 per policy year.

(4) A policy which provides benefits for the payment for or furnishing of hospitalization, drugs, attending physicians and surgical costs in the aggregate of $1,000.00 per policy year.

(5) A policy providing accidental death benefits of $1,000.00.

B. REPEALED BY ACTS 1997, No. 184, §2.

C. The limits provided in Paragraphs A and B above shall be increased to the underwriting limits provided in R.S. 22:258 for those insurers who are entitled to increased underwriting powers under its provisions.

D. No insurer shall issue an industrial life insurance policy on more than a single life, except life insurance covering the spouse and/or the minor children of an insured under a policy naming each member of the insured's family thereby covered and stipulating a separate premium for each such family member determined according to the attained age of each.

Acts 1958, No. 125. Amended by Acts 1958, No. 95, §1, eff. Jan. 1, 1959 at 12:00 Noon; Acts 1960, No. 431, §1; Acts 1974, No. 4, §2; Acts 1997, No. 184, §§1, 2.

§253. Funeral described; benefits payable

A.(1) Every funeral policy shall state the dollar value of the funeral to be furnished and shall specify therein those benefits which shall constitute the funeral to be furnished. If upon the death of the insured, the dollar value of the funeral to be furnished, as stated in the policy or policies, is less than the retail price of the funeral benefits specified in the policy or policies, the beneficiary shall be entitled to a cash payment which shall be equal to one hundred percent of the face amount of the policy or policies.

(2) It is the intent of the legislature that under no circumstances shall an insurer be required to provide services or reimburse to a beneficiary at amounts greater than the stated dollar amount of the policy.

(3) The provisions of this Subsection are interpretive of Part VII of Chapter 1 of the Louisiana Insurance Code and are intended to explain the original intent.

(4) The provisions of this Subsection shall be applicable to all claims existing or actions pending on its effective date and all claims arising or actions filed on or after its effective date. The provisions of this Paragraph shall not be construed to effect any claim arising from or involving any misrepresentation as to the terms and conditions of the policy by an insurer or its agent to the insured.

B.(1) If for any reason the beneficiary does not avail himself of the contractual services as set forth in the funeral policy, in lieu thereof, the policy shall provide for a stated cash payment, which shall not be less than one hundred percent of the face amount of the policy on policies written after January 1, 1978.

(2) If the casket offered is not the casket described in the policy, the beneficiary may choose to not accept the offered casket and the funeral provider shall agree to substitute a casket other than the one offered by the funeral provider. The beneficiary shall be entitled to select and purchase the substitute casket at retail without forfeiting the remaining contractual funeral services specifically enumerated in the policy.

(3) If for any other reason the beneficiary and the funeral provider agree to substitute a casket other than the one described in the policy, the beneficiary shall be entitled to select and purchase the substitute casket at retail without forfeiting the remaining contractual funeral services specifically enumerated in the policy.

C. Every funeral policy which includes among its benefits the payment for burial lot, tombstone, marker, plot, tomb, vault or coping shall state in dollars the value of the said benefits, and shall specify therein those things which shall constitute the said benefits to be furnished. Such policy shall be valued without the reduction of reserves provided for in R.S. 22:162. In the event such services are not furnished or paid for by the insurer then the amount of insurance shall be paid in cash to the beneficiary by the insurer, at the option of the beneficiary.

D. No funeral service policies as described in R.S. 22:252, R.S. 253, 291(1), 332, and 337 shall be sold after 12:00 midnight July 31, 1997.

Acts 1958, No. 125. Amended by Acts 1962, No. 329, §1; Acts 1964, No. 124, §1; Acts 1972, No. 246, §1, eff. Jan. 1, 1973; Acts 1977, No. 116, §1, eff. Jan. 1, 1978; Acts 1997, No. 949, §1; Acts 2004, No. 689, §1, eff. July 6, 2004.

§254. Capital requirements

All domestic insurers organized after 12:00 noon on July 27, 1960, qualifying to write industrial life insurance only, shall, in lieu of the capital requirements of R.S. 22:71, or the minimum surplus requirements of R.S. 22:121 and 22:122, have a paid-in capital of thirty thousand dollars, and a minimum surplus of thirty thousand dollars, if a stock insurer, or a minimum surplus of sixty thousand dollars, if a mutual insurer, before beginning business.

Acts 1958, No. 125. Amended by Acts 1960, No. 150, §1.

§255. Deposit

A.(1) All domestic industrial insurers organized after 12:00 noon on the effective date of this Act, shall deposit with the commissioner of insurance a safekeeping or trust receipt from a bank doing business in Louisiana, or a savings and loan association chartered to do business in Louisiana, indicating that fifty thousand dollars in money, or approved bonds of the United States, the state of Louisiana, or any political subdivision thereof, of the par value of not less than fifty thousand dollars has been deposited.

(2) All domestic industrial insurers already organized and qualified as of 12:00 noon on the effective date of this Section, shall maintain the minimum deposit required under the law as of that date, and thereafter shall increase their deposit at the rate of five hundred dollars for each one thousand new policyholders until said deposit reaches fifty thousand dollars.

B. This deposit shall be held subject to any claim, lien, or judgment that may be judicially obtained against any such insurer in any court of this state or any federal court in this state, arising from any contract of insurance entered into in this state.

Acts 1958, No. 125. Amended by Acts 1960, No. 151, §1; Acts 1974, No. 4, §2; Acts 1981, No. 856, §1; Acts 1982, No. 748, §1.

§256. Nonforfeiture benefits

A. From and after twelve o'clock noon of October 1, 1948, no policy of industrial life insurance, other than a term policy of twenty years or less, shall be issued or delivered in this state unless the same shall contain in substance the following provisions: that in the event of default of premium payments, after premiums have been paid for five years, the insured shall be entitled to a stipulated form of insurance, or a cash value, the net value of which shall be at least equal to two-thirds of the reserve on the policy at the end of the policy quarter year nearest to the date to which premiums have been paid, computed in accordance with R.S. 22:162 from which any existing indebtedness to the company on or secured by the policy shall be deducted, provided that the said reserve shall not be less than the legal minimum standard, as provided in this Code, for such valuation of policies, and that in computing paid-up or extended insurance granted as a nonforfeiture benefit under this section, the insurer may use single premiums based upon the Standard Industrial Table of Mortality with interest at not more than three and one-half percent per annum.

B. Within eight weeks after the due date of the first defaulted premium on policies of industrial life insurance on which premiums have been paid for five full years, application shall be made in writing by the assured, on blanks to be furnished by the insurer at the insured's request for that purpose, for paid-up insurance, payable at the same time, and under the same conditions, except as to payment of premiums, as the original policy, or for the continuance of the insurance in force at its full amount, less any indebtedness to the insurer, for such period as the net reserve will purchase, or for cash value of the policy, all computed as hereinabove provided. The term of temporary insurance herein provided for shall include the period of grace, if any. If no option herein provided for shall be availed of by the assured, the reserve herein provided, without further action on the part of the assured, shall be applied either to purchase paid-up insurance or to continue the insurance in force at its full amount as hereinabove provided. However, in the case of any endowment policy, if the sum applicable to the purchase of temporary insurance be more than sufficient to continue the insurance to the end of the endowment term named in the policy the excess shall be used to purchase in the same amount pure endowment insurance payable at the end of the endowment term named in the policy under the conditions on which the original policy was issued. The policy shall state which of the two forms will be automatic. In calculating nonforfeiture values as herein provided there shall be included all dividend additions from participating policies.

C. The insurer shall, at any time after five full years' premiums have been paid at the request of the insured in writing, furnish the insured with a statement showing the nonforfeiture benefits available under his policy in terms of dollars, and years, months and days of insurance protection, unless this information is shown by appropriate tables in his policy.

D. Any condition or stipulation in any policy of industrial life insurance contrary to the provisions of this section, or any attempted waiver of such provisions shall be void. Nothing in this section shall limit the right of industrial life insurers to include multiple indemnity benefits in any policy issued by them.

E. A table or tables showing the cash value and the insurance available as an automatic option must be included in each policy, except funeral policies which must contain a table showing the insurance available as an automatic option.

Acts 1958, No. 125. Amended by Acts 1958, No. 93, §1; Acts 1974, No. 4, §2.

§257. Policies under standard non-forfeiture law excepted

The provisions of R.S. 22:256 shall not apply to any policy issued by any industrial insurer under the provisions of R.S. 22:168.

Acts 1958, No. 125.

§258. Powers of existing industrial insurers

Industrial insurers already organized and qualified under the industrial laws of this state as of twelve o'clock noon of October 1, 1948, shall continue to have the same underwriting powers they had as of that date without the necessity of meeting the increased capital or deposit requirements of this code. All policies issued subsequent to twelve o'clock noon of October 1, 1948, by such insurers must conform to the provisions of this code, except as to the amount of insurance which may be written on a single life. No industrial insurer, not authorized to write policies in excess of one thousand two hundred fifty dollars as of twelve o'clock noon of October 1, 1948, can acquire such authority except by conversion to another type insurer, provided, however, that when any domestic industrial insurer, not so previously authorized, shall meet the minimum capital, surplus and deposit requirements, if a stock company, or the minimum initial surplus and deposit requirements, if a mutual company, required by this code of an ordinary insurer, it may, after appropriate charter amendment and without conversion to an ordinary insurer, or after conversion, issue industrial insurance on a single life in an amount not to exceed two thousand five hundred dollars exclusive of multiple indemnity, subject to all other provisions of this part applicable to industrial insurers except as to amount.

Acts 1958, No. 125. Amended by Acts 1974, No. 4, §2.

§259. Required policy provisions

All industrial life insurance policies, delivered or issued for delivery in this state, shall contain, in substance, the following provisions, or provisions submitted by the insurer which in the opinion of the commissioner of insurance are more favorable to policyholders:

(1) A provision that the insured is entitled to a grace period of four weeks within which the payment of any premium after the first may be made, except that where premiums are payable monthly, or less frequently, the period of grace shall be either one month or thirty days, during which period of grace the policy shall continue in full force but in case the policy becomes a claim within said grace period any overdue premiums may be deducted in any settlement under the policy.

(2) A provision that the policy shall constitute the entire contract between the parties, or at the option of the insurer, a provision that the policy and the application therefor shall constitute the entire contract between the parties, and in the latter case the policy must contain a provision that all statements made by the insured shall, in the absence of fraud, be deemed to be representations and not warranties.

(3)(A) A provision that the policy shall be incontestable after it shall have been in force during the lifetime of the insured for a specified period, not more than two years from its date, except for nonpayment of premiums and except for violation of the conditions of the policy relative to naval or military service, or services auxiliary thereto, and except as to provisions relating to benefits in the event of disability as defined in the policy, and those granting additional insurance specifically against death by accident or by accidental means, or to additional insurance against loss of, or loss of use of, specific members of the body. Provided a clause in any policy of industrial life insurance issued under this Code providing such policy shall be incontestable after a specified period shall preclude only the contest of the validity of the policy, and shall not preclude the assertion at any time of defenses based upon provisions which exclude or restrict coverages approved in this paragraph (3) whether or not such restriction or exclusions are excepted in such clause; nor upon a provision regarding misstatement of age as provided in paragraph (4), of this Section, whether or not such provision is excepted in such clause.

(B) No policy of industrial life insurance issued under this Section shall contain any provision which excludes or restricts liability for death caused in a certain specified manner or occurring while the insured has a specified status, except the following provisions, or provisions which in the opinion of the insurance commissioner are substantially the same or more favorable to the policyholders:

Provisions excluding or restricting coverage in the event of death occurring:

(a) As a result of war declared or undeclared under conditions specified in the policy.

(b) While in

(i) the military, naval or air forces of any country at war declared or undeclared, or

(ii) any ambulance, medical, hospital, or civilian noncombatant units serving with such forces, either while serving with or within six months after termination of service in such forces or units.

(c) As a result of self-destruction while sane or insane within two years from the date of issue of the policy.

(d) As a result of aviation under conditions specified in the policy.

(e) Within two years from date of issue of the policy as a result of a specified hazardous occupation or occupations, or while the insured is residing in a specified foreign country or countries.

In the event of death as to which there is an exclusion or restriction pursuant to sub-paragraphs (a), (c), (d), or (e) of this provision, the insurer shall pay an amount not less than the reserve on the policy, together with the reserve for any paid-up additions thereto and any dividends standing to the credit of the policy, less any indebtedness to the insurer on the policy, including interest due or accrued.

In the event of death as to which there is an exclusion or restriction pursuant to sub-paragraph (b) of this provision, the insurer shall pay the greater of (a) the amount specified in the preceding paragraph or (b) the amount of the gross premiums charged on the policy less dividends paid in cash or used in the payment of premiums thereon and less any indebtedness to the insurer on the policy, including interest due or accrued.

None of the provisions of this sub-section shall apply to policies issued under Sections 253 and 162E, nor to any accidental benefits in the event such death be by accident or accidental means included in a life policy.

(4) A provision that if the age of the person insured (or the age of any other person considered in determining the premium) has been misstated, any amount payable or benefit accruing under the policy shall be such as the premium paid would have purchased at the correct age or ages.

(5) If the policy is a participating policy, a provision that the insurer shall periodically ascertain and apportion any divisible surplus accruing on the policy.

(6) A provision that the policy may be reinstated at any time within one year from the due date of the premium in default unless the cash surrender value has been paid, or the extension period expired, upon the production of evidence of insurability including good health satisfactory to the insurer and the payment of all overdue premiums and any unpaid loans or advances made by the insurer against the policy with interest at a rate not exceeding six percent payable annually.

(7) A provision that when a policy shall become a claim by the death of the insured, settlement shall be made upon receipt of due proof of death or after a specified period not exceeding two months after receipt of such proof.

(8) A title on the face of the policy briefly describing its form.

(9) A space on the front or back page of the policy for the name of the beneficiary designated with a reservation of the right to designate or change the beneficiary after the issuance of the policy. The policy may also provide that no designation or change of beneficiary shall be binding on the insurer until endorsed on the policy by the insurer, and that the insurer may refuse to endorse the name of any proposed beneficiary who does not appear to the insurer to have an insurable interest in the life of the insured. Such policy may also contain a provision that the insurer may make any payment or grant any non-forfeiture provision to any of the insured's relatives by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled thereto by reason of having been named beneficiary, or by reason of having incurred expense for the maintenance, medical attention or burial of the insured, and the production by the insurer of a receipt signed by any of said persons shall be evidence that such payment or privilege has been made or granted to the person or persons entitled thereto and that all claims under the policy have been fully satisfied.

Acts 1958, No. 125. Amended by Acts 1958, No. 96, §1; Acts 1960, No. 168, §1.

§260. Exceptions

The requirements in R.S. 22:259 shall not be applicable as follows:

(1) When an industrial life insurance policy is issued by any domestic, foreign, or alien insurer providing other benefits, in addition to life insurance, the foregoing provisions shall apply only to the life insurance portion of the policy.

(2) Any of the foregoing provisions or portions thereof not applicable to non-participating or term or paid-up policies shall to that extent not be incorporated therein.

Acts 1958, No. 125.

PART VIII. DOMESTIC SERVICE INSURERS

§291. Service insurance defined

Service insurance is hereby defined and shall be construed to be that insurance for which stipulated premiums are regularly payable and collectible and the policies or benefit certificates for which:

(1) Promise or agree to furnish the insured a funeral, the value of which shall not exceed five hundred dollars, or

(2) Promise or agree to furnish hospitalization to the insured upon his sickness or other physical disability, not exceeding five hundred dollars in any policy year.

Acts 1958, No. 125.

§292. Policy provisions

A. No service insurer shall issue a policy for a term of more than 20 years and all policies issued shall be incontestable after the lapse of one year from the date of its issue, except for non-payment of premiums or assessments. Thirty days written notice must be given to the policyholder before any policy shall be lapsed or forfeited for non-payment of premiums or assessments. All policy forms, endorsements, riders, and applications must be submitted to and approved by the Commissioner of Insurance before being used.

B. Each policy must specify those things which constitute the service to be furnished, performed, or rendered; and must also provide on the face of the funeral benefit policy a stated cash payment which will be made in lieu of such services in the event it is impossible or impractical to furnish such services as set forth in the policy. This cash payment shall be not less than one hundred percent of the stated value of such services on policies written after the effective date of this Section.

C. If for any reason the beneficiary does not avail himself of the contractual services as set forth in the funeral policy when it is practical and possible to furnish such services, then, in lieu thereof, the policy shall provide for a stated cash payment which shall not be less than seventy-five percent of the face amount.

D. Such funeral policies shall also conform to the requirements of R.S. 22:259, Paragraphs (2), (4), (5), (6), (7), (8), and (9).

Acts 1958, No. 125. Amended by Acts 1964, No. 125, §1; Acts 1972, No. 246, §1, eff. Jan. 1, 1973; Acts 1977, No. 116, §1, eff. Jan. 1, 1978.

§293. Deposits

A. All domestic service insurers shall, in addition to all other requirements, deposit with the commissioner of insurance a safekeeping or trust receipt of a bank doing business within this state or a savings and loan association chartered to do business in this state, indicating that five thousand dollars in money or approved bonds of the United States, the state of Louisiana, or any political subdivision thereof, of the par value of not less than twenty thousand dollars has been deposited, the value thereof to be maintained; which deposit shall be held subject to the claim of any judgment creditor arising and accruing by virtue of any policy or certificates issued by such insurer, through judgment obtained against it in any court of this state, or in any federal court in this state.

B. Service insurers already organized and qualified under the laws of this state as of the effective date of this Section shall continue to have the same underwriting powers they had as of that date, provided all such insurers shall increase the deposit requirement to the amount set out in Subsection A of this Section on or before October 1, 1982.

Acts 1958, No. 125. Amended by Acts 1960, No. 166, §1; Acts 1981, No. 856, §1; Acts 1982, No. 748, §1.

§294. Capital requirements

All domestic insurers qualifying to write service insurance only shall in lieu of the capital requirements of R.S. 22:71 or the minimum surplus requirements of R.S. 22:121 and 22:122, have a paid-in capital of ten thousand dollars and a minimum surplus of five thousand dollars, if a stock insurer, or a minimum surplus of fifteen thousand dollars, if a mutual insurer, before beginning business. All service insurers authorized as of 12:00 noon on July 27, 1960 may continue to operate without meeting the increased capital and surplus requirements.

Acts 1958, No. 125. Amended by Acts 1960, No. 174, §1.

§295. Incorporation of service insurers prohibited

No domestic service insurance company may be organized and no alien or foreign service insurer may be qualified hereunder to do business in this state after twelve o'clock noon of August 1, 1964.

Added by Acts 1964, No. 151, §1.

PART IX. NON-PROFIT FUNERAL SERVICE ASSOCIATIONS

§331. Definitions

For the purposes of this Part, the terms stated below have the meanings assigned to them, respectively, unless the context otherwise requires:

"Non-profit funeral service association" or "non-profit association" means a corporation organized, incorporated and operated under the provisions of this Part which furnishes to its policyholders funeral services, supplies and other benefits hereinafter authorized on the assessment or co-operative plan, but the term shall not be construed to affect or apply to grand or subordinate lodges of Masons, Odd Fellows, Knights of Columbus, Daughters of America, or to any other fraternal benefit society organized and qualified prior to 12:00 noon October 1, 1948.

"Policyholder" means any person who is named as a beneficiary in a policy or certificate of membership issued by a non-profit funeral association.

"Insured bank" means a bank, the deposits of which are insured by the Federal Deposit Insurance Corporation.

"Funeral services and supplies" means the general and usual services rendered and supplies furnished by undertakers, embalmers and funeral directors.

Acts 1958, No. 125.

§332. Incorporation and qualification of incorporators

Five or more natural persons residents of this state of full age, or fully relieved by emancipation of all disabilities attaching to minority, may form a non-profit corporation, under the provisions of this Part, having for its purpose the establishing, maintaining, and operating of a non-profit funeral service plan.

No such insurer, however, may be organized and no alien or foreign insurer may be qualified hereunder to do business in this state after 12:00 noon of August 1, 1956.

All associations now operating and authorized under this Part, as of 12:00 noon, August 1, 1956, to do business in this state, may continue to operate, provided that, from and after December 31, 1956, all policies issued by such insurers and the income therefrom and investment thereof, shall be subject to and in accordance with the laws and regulations of this state relative to industrial life insurance, and especially subject to the provisions of this Code relative to domestic industrial insurers, and shall be authorized to issue only funeral benefit policies in amounts not exceeding an aggregate of $500.00 (including the amount of any existing assessment policies) on any single life, with no multiple indemnity benefits. The operation of all present insurers shall be governed by the provisions of this Part, and by all the applicable provisions of this Code.

Acts 1958, No. 125.

§333. Articles of incorporation

Articles of incorporation shall be executed by authentic act signed by each of the incorporators, or by his agent duly authorized by authentic act, which authorization shall be attached to the articles of incorporation, and shall state:

(1) The name of the association;

(2) That it is formed for the purposes of establishing, maintaining and operating a non-profit funeral service plan;

(3) Its duration;

(4) The location and post office address of its principal office;

(5) The full names and post office addresses of officers designated by it for service of process;

(6) The number, terms of office and manner of election of directors and officers, the names and post office addresses and respective titles of the first officers;

(7) Provisions for meetings at least annually of the policyholders;

In addition to the above the articles may contain any provision creating, defining, dividing, limiting or regulating the powers of the directors, officers, policyholders or any other provisions not inconsistent with this Part or the laws of this state for the carrying out of the purposes and the conduct of the affairs of the association.

Acts 1958, No. 125.

§334. The corporate name

The corporate name must end with the words "Funeral Association" or the words "Funeral Association Incorporated" or the words and abbreviation "Funeral Association, Inc."

The corporate name shall not be the same as nor deceptively similar to the name of any other domestic insurer nor any foreign insurer authorized to do business in this state.

Acts 1958, No. 125.

§335. Filing and recording articles; application for certificate of authority; issuing certificates of incorporation and authority

A. The articles, or a multiple original thereof, shall be recorded in the office of the recorder of mortgages of the parish in which the registered office of the association is situated and a certified copy of the articles bearing the certificate of the proper recorder of mortgages showing the date when the articles were filed for record in his office, together with an application signed by the first directors for a certificate of authority to operate under this Part shall be delivered to the commissioner of insurance. If the commissioner of insurance finds the facts conform to the law, he shall approve same, and the Articles shall be recorded in the manner specified in R.S. 22:34.

B. There shall be attached to the application for certificate of authority the following:

(1) A sworn statement of its president or vice-president and treasurer showing:

(a) The number of persons, which shall not be less than five hundred, who have in good faith, made application in writing for policies and the number of those persons who fall within each class or group as provided in the by-laws of the association;

(b) That there has been created and deposited with an insured bank to the credit of the association a sum of money as a reserve fund equal to the aggregate amount of the initial membership fees, as required by the by-laws, of all persons who have made application in writing for policies or the sum of ten thousand dollars, whichever is the greater;

(c) That the association has created no debts and is under no obligation except to issue policies to the persons who have made application therefor:

(2) Copies of proposed forms of applications, policies, or membership certificates and by-laws;

(3) Treasurer's fidelity bond in the sum of two thousand five hundred dollars, signed by the treasurer of the association and a surety approved by the commissioner of insurance.

C. When all taxes, fees and charges have been paid as required by law, the provisions as outlined in R.S. 22:34 shall be complied with.

Acts 1958, No. 125.

§336. Application for policies

All applications for policies shall be signed on a written, typewritten or printed form identical with the form of application filed with the commissioner of insurance for policies of the type to be issued and, in addition to the signature of the applicant, or his mark in case he is unable to write, must be signed by the officer or agent of the association soliciting or receiving the application. No agent may sign any application which he has not personally solicited or received.

The applications for policies must state the age on the nearest birthday of each person for whose benefit the application is made; that no person named in the application as a beneficiary is less than one month nor more than seventy years of age; that each person named in the application as a beneficiary is in good health, free from any chronic disease, not under treatment by any doctor and that, subject to its incontestability after one year from its date, except for non-payment of assessments, any misrepresentation in the application in regard to the health or age of any beneficiary at the time the application is signed will forfeit all rights to policy benefits; and such other statements not inconsistent herewith as may be required by the articles or by-laws.

All applications for policies must be kept on file in the office of the association. When any policyholder shall die, the application of such policyholder shall be retained for a period of at least three years after his death and the original applications for all policies which subsequently become lapsed or forfeited shall be retained for a period of at least three years after the date of the lapse or forfeiture thereof.

A policyholder in good health and not over seventy years of age who has permitted his policy to lapse may rejoin upon terms fixed in the by-laws of the association and signing a statement in regard to his health as in the original application. Policyholders whose policies have lapsed and who are over seventy and under ninety years of age may reinstate only in the old age group.

In the case of family group policies the application must be signed by one or more members of the family group to be covered by the policy.

Acts 1958, No. 125.

§337. Policies

A. Every policy issued by any association authorized under this Part shall have plainly printed on the first page thereof the words "Assessment or Co-operative Plan", shall specify the services which it promises to furnish, the contingency upon which it agrees to furnish the same, the name of each beneficiary, the class or group in which each beneficiary is placed, the amount of each assessment to be required of each beneficiary and the value of the benefit to be furnished each beneficiary. There shall be printed on each policy, either on the reverse thereof or a sheet attached thereto, a copy of the bylaws of the association. The policy may also contain any other provision, language, or appendage not calculated to operate as a fraud upon, or mislead, the policyholder.

B. No policy shall be issued which provides for any benefit in excess of three hundred dollars for any one individual and no policy shall be issued which provides for any benefit in excess of two hundred dollars for any person who is at the time of the issuance of the policy more than sixty years of age.

C. No person may hold a policy of more than one association at one time. When one person holds more than one policy, the one first issued shall be regarded as in effect and policies subsequently issued as null and void.

D. Groups of insureds seventy years of age or older are authorized, but all records, accounts, funds, expenses, and other matters shall be kept separate from other groups.

E. Every policy issued by any association authorized pursuant to this Part shall be incontestable after one year from the date of its issue except for nonpayment of assessments.

Acts 1958, No. 125; Acts 1999, No. 1304, §1, eff. July 12, 1999.

§338. By-laws

The board of directors of an association authorized under this Part may make and alter by-laws not inconsistent with the law or articles. The initial by-laws filed with the articles shall be signed by the first directors named in the articles.

The by-laws of all associations authorized under this Part shall contain:

(1) A statement that the treasurer shall make all assessments and pay out all money belonging to the association;

(2) The name of the undertaker or funeral directing firm with which the association has contracted to furnish the services specified in the policies;

(3) A description of the various classes or groups into which the policyholders are divided, the benefits to be furnished each class or group, the amount of the assessment of the members of each class or group and the contingency upon which the assessment shall or may be made;

(4) The period of delay after assessment, which shall be not less than thirty days, within which assessments must be paid in order to prevent the forfeiture of policies;

(5) The person, firm or corporation to be notified in event of the death of a policyholder or beneficiary;

(6) The time and place of the annual meeting of policyholders;

(7) The notice and manner of calling special meetings of policyholders; and may contain any other lawful provisions which may be desired for the purpose of defining, limiting and regulating the exercise of the authority of the association, directors, officers or policyholders.

Acts 1958, No. 125.

§339. Amendment of articles and by-laws

The articles may be amended by the board of directors with the approval of the commissioner of insurance. The amendment shall be adopted by the board at any regular or special meeting and then submitted to the commissioner of insurance, who shall approve the same unless it is contrary to law. Upon its approval by the commissioner of insurance the amendment shall be recorded in the manner provided in R.S. 22:38.

The board of directors may at any regular or special meeting adopt amendments to the by-laws, subject to the approval of the commissioner of insurance, but no amendment that provides for the extension of the benefits of the policies of the association to a group or class of persons not previously provided for or provides for any change with respect to the benefits to be furnished any group or class of policyholders or provides for any change regarding the amount of any assessments or contingency upon which any assessment shall or may be made or provides for any change as to the period of delay within which assessments must be paid in order to prevent the forfeiture of policies or changes the time or place of the annual meeting of policyholders, shall be approved unless ratified by the policyholders at a regular or special called meeting of policyholders.

Acts 1958, No. 125.

§340. Directors

Subject to such limitations, restrictions or reservations as may be provided in the articles, the by-laws or this Part, all of the corporate powers shall be vested in and the affairs of the association shall be managed by a board of not less than three nor more than fifteen directors who must be policyholders in good standing.

The number, qualifications, terms of office, manner of election, time and place of and manner of calling and holding meetings, powers and duties, method of and cause for removal of directors may, subject to the provisions of this Part, be prescribed by the articles or by-laws.

Unless otherwise provided in the articles, a majority of the board of directors shall be necessary to constitute a quorum for the exercise of any of the powers conferred by the articles or this Part upon the board.

Acts 1958, No. 125.

§341. Officers and agents

The board of directors shall elect a president, a vice-president, a secretary and a treasurer, all of whom, except the treasurer, shall be members of the board of directors. Any two of the above named officers may be combined in one person and should the office of treasurer and another one of said officers be combined in one person, said officer need not be a member of the board of directors. The treasurer may be a member of the board.

The president shall be ex-officio chairman of the board of directors. He shall preside at all meetings of the said board and at all meetings of the policyholders, and shall perform such other duties and functions as are required or permitted by this Part and the provisions of the articles. In the absence of the president, the vice-president shall act in his place and stead.

The secretary shall record all proceedings of the meetings of the board of directors and policyholders and perform such other duties and functions as are required or permitted by this Part and the provisions of the articles.

The qualifications, terms of office, manner of election and the powers and duties of the officers may, subject to the provisions of this Part, be prescribed by the articles or by-laws. No person shall solicit, write, or issue any policy under this Part without having first been duly licensed by the commissioner of insurance as an agent.

Acts 1958, No. 125.

§342. Policyholders' meetings

Meetings of the policyholders shall be held at such times and places as the articles and by-laws may provide but the articles and by-laws shall provide for the manner of calling and the notice to be given of special meetings of the policyholders. The articles or by-laws shall provide that notice of any special meeting of policyholders shall be in writing addressed to each policyholder and deposited in the mails at the location of the office of the corporation with postage paid not less than fifteen days prior to the meeting date.

In case of family group policies, notice given to the head of the family group covered thereby shall be deemed sufficient notice to all of the members of such group.

The policyholders present at any regular or special meeting of policyholders shall constitute a quorum and any act which requires the authorization or approval of the policyholders shall be valid if authorized or approved by the majority of those present at any such meeting.

Acts 1958, No. 125.

§343. Funds

A. All funds of every association operating under this Part shall be deposited with one or more insured banks doing business in the state of Louisiana. Two separate funds shall be maintained by each association, one to be known and designated with the depository as a general fund and the other to be known and designated with the depository as a reserve fund. The reserve fund shall not exceed the deposit amount insured by the Federal Deposit Insurance Corporation (FDIC) in any one institution.

B. All funds of any association, exc ept its reserve fund, shall be deposited in the general fund and may be withdrawn only by check or voucher for the purpose of paying benefits for policyholders and expenses authorized by the provisions of this Part.

C. Ten percent of the aggregate amount received from each assessment shall be deposited in a reserve fund until a reserve of ten thousand dollars is accumulated. Nothing contained herein shall prevent the accumulation of larger reserves if desired. Said reserve fund may not be used for any purpose except at the direction of the commissioner of insurance upon the liquidation or dissolution of the association or its merger with another association, or unless an emergency exists which makes it necessary or advisable to withdraw part of the reserv e for the purpose of paying benefits for policyholders, in which event the withdrawal of such parts thereof as may be necessary to meet the emergency may be authorized by the commissioner of insurance and made for said purpose upon satisfactory provisions for the reaccumulation of the reserve so withdrawn. Any association may accept any gift or donation inter vivos or mortis causa provided the same does not create any obligation upon the association, and unless otherwise designated by the donor, the proceeds of such gift or donation shall be deposited in the general fund of the association.

D. No money may be borrowed by the association and the assets of the association may not be pledged for any purpose. Except as hereinafter authorized, the funds of the association may not be loaned for any purpose. The reserve fund of the association may only be invested in bonds of the state of Louisiana, the United States of America, or cash, and deposited with a bank authorized to do business in the state of Louisiana, with a safekeeping or trust receipt from the bank deposited with the commissioner of insurance.

Acts 1958, No. 125. Amended by Acts 1981, No. 856, §1; Acts 1993, No. 784, §1.

§344. Service

Except as hereinafter authorized, funeral services and supplies only can be furnished by any association operating hereunder and payment therefor shall be made to the undertaker or funeral directing firm furnishing the funeral and not the family of the deceased. The funeral services and supplies shall be furnished by the undertaker or funeral directing firm named in the by-laws of the association but in a case of emergency the undertaker or firm so named, upon being notified of the death of a policyholder, may select another undertaker or firm to provide the services and supplies, in which event payment of the stipulated benefit shall be made in cash to the undertaker or funeral directing firm named in the by-laws of the association.

Acts 1958, No. 125.

§345. Uniform classes of policyholders and stipulated benefits; assessments

A. The classification or grouping of policyholders into classes according to age and the value of the benefit provided in the policies shall be uniform and, except as hereinafter specified, all associations operating hereunder shall prescribe the same per capita rate of assessment for each class or age group entitled under the provisions of its policies to the same amount of benefit.

B. The classification or groupings of policyholders and per capita assessment of each class or group shall be filed with the commissioner of insurance.

C. Any association operating hereunder may issue policies embracing any or all the approved classifications or groupings of policyholders until December 31, 1982, and provide for the payment of benefits and per capita rates of assessment accordingly, but except as herein expressly authorized, shall not adopt any different classifications, groupings, or rates.

D. Policies providing for benefits not in excess of one hundred fifty dollars may be issued to persons between the ages of seventy and ninety years at special rates approved by the commissioner of insurance.

E. Policies may, in addition to the benefits herein specially authorized, provide for the payment of a thirty-five dollar benefit for children of policyholders who are stillborn or who die before reaching the age of three months.

F. Assessments must be made often enough to provide funds to meet the current obligations of the association, keep out of debt, and maintain the reserve fund required by this Part, and in no case shall any association levy less than four assessments annually. At least once every year there shall be furnished to all policyholders a statement of the receipts and disbursements since the previous statement, a list of the names of the policyholders who have died since the date of the previous statement, and the amount or value of the benefit furnished to each.

G. All policyholders receiving policies more than sixty days prior to an assessment must be included in the assessment.

Acts 1958, No. 125. Amended by Acts 1964, No. 152, §1; Acts 1981, No. 386, §1, eff. Jan. 1, 1982.

§346. Expenses

The expenses of necessary printing, stationery, postage, office supplies and expenses, clerical hire, statutory fees, examination fees, may be paid by the association. The total of all expenses shall not exceed 25% of each assessment and shall be paid out of the general fund of the association.

Acts 1958, No. 125.

§347. Indebtedness

All associations are prohibited from creating any indebtedness except for expenses and benefits to policyholders and all debts for expenses and benefits to policyholders must be paid within sixty days after they arise.

Acts 1958, No. 125.

§348. Books and records

Every association shall keep at its office a record of all proceedings of the board of directors and policyholders in regular or special called meetings and shall keep such other books, accounts and records as may be necessary to accurately reflect at all times the actual condition of the association and whether or not it is complying with the provisions of this Part, the articles and by-laws. All records of the association shall be available for inspection by representatives of the office of the commissioner of insurance and the policyholders at all times. The books of an association may be closed not more than thirty days prior to an assessment.

Acts 1958, No. 125.

§349. Examinations

A representative of the office of the commissioner of insurance shall make an examination of the books, papers, and affairs of each association once in every five years and may make an examination more often if it is made to appear to the commissioner of insurance that the association is not complying with the provisions of this Part or its articles or bylaws.

Acts 1958, No. 125; Acts 1997, No. 1449, §1.

§350. Reports and financial statements

Every association shall, on or before the first day of March in each year, make and file with the commissioner of insurance a report of its affairs and its operations during the year ending on the 31st of December immediately preceding. Such report shall be signed by the president or vice-president and the secretary and treasurer and shall contain the following:

(1) The number of policies in force at the beginning and at the end of the year and the aggregate face value thereof;
(2) The number of policies issued during the year;
(3) The number of policies lapsed during the year;
(4) The number of death losses;
(5) The number of death losses paid;
(6) The number of death losses compromised or resisted and a brief statement of the reason;
(7) The number of assessments which have been made during the year;
(8) The total amount received from death assessments during the year;
(9) The total amount of benefits paid on death losses;
(10) An itemized statement of all expenses paid during the year;
(11) The amount of general funds, the amount of the reserve fund, the name of the bank or banks wherein the same are deposited, and the amount on deposit with each depository.

Acts 1958, No. 125.

§351. Expiration of certificate of authority; renewal

Every certificate of authority issued by the commissioner of insurance to any association, and agents' licenses issued under this Part shall continue in force until the 31st day of March, inclusive, next following its issuance, unless the same be sooner revoked, and shall be reinstated each year upon compliance with all of the provisions of this Part.

Acts 1958, No. 125.

§352. Merger and consolidation

Any two or more associations operating under this Part having in the aggregate a number of policyholders of not less than five hundred to each of the constituent associations may merge or become consolidated by complying with the provisions of this Section.

The boards of directors of the constituent associations shall enter into an agreement by authentic act setting forth the terms, conditions and the plan of the proposed merger or consolidation and shall submit the same to the commissioner of insurance for his approval. If from an examination made by him or his authorized representative it shall appear to the commissioner of insurance that the proposed plan is feasible and that the same will not operate injuriously to the policyholders of any of the constituent associations, he shall approve the same and the merger or consolidation shall become effective upon his approval. The commissioner of insurance may if he deems it advisable, direct that meetings of the policyholders of the constituent associations or any of them be called for the purpose of ratifying or approving the proposed plan.

In addition to the above any association incorporated or hereinafter incorporated under the provisions of this Part, may with the consent of the board of directors and any other association or corporation operating a non-profit funeral association other than under the provisions of this Part by and with the consent of the officers and/or board of directors of the other association or corporation, as provided for under the by-laws, rules and regulations of the association or corporation, and upon approval of the commissioner of insurance or his authorized representative, if the plan shall appear to the commissioner of insurance or his authorized representative to be feasible and that the same will not appear to operate injuriously to the policyholders of either association, shall by written contract in authentic form, assume the debts, policies and obligations of the other association or corporation, and continue to satisfy the terms and conditions of the outstanding policies and/or contracts under the same rates as provided for in the policies until all policies outstanding have expired, provided that all new policies shall be issued according to the provisions of this Part, and by and under the name of the association incorporated under the provisions of this Part.

Acts 1958, No. 125.

§353. Liquidation

Whenever the board of directors of any association operating under this Part shall be desirous of discontinuing the operations of the association, it shall immediately notify the commissioner of insurance and submit a plan for the liquidation of the association. The commissioner of insurance shall cause an examination of the association to be made and if it appears that the association has complied with all the provisions of this Part, he shall direct that a meeting of the policyholders be called, at which meeting the proposed plan of liquidation shall be submitted and if approved by the policyholders, shall be carried into effect. At such meeting the policyholders shall be permitted, if they elect to do so, to elect a new board of directors and in lieu of liquidating continue the operation of the association. Should the policyholders disapprove of the plan of liquidation and fail to reorganize in such a manner as to continue the operation of the association, the association shall be liquidated under the direction of the commissioner of insurance as in the case of associations which have persisted in the violation of the provisions of this Part, the articles or by-laws.

Whenever it appears to the commissioner of insurance that any association is failing to comply with the provisions of this Part or its articles or by-laws in any respect, he shall immediately notify the officers of the association to that effect, specifying in what respects it is claimed that the association is failing to comply and if after such notice the association persists in the violations of the provisions hereof, the commissioner of insurance shall proceed to apply for liquidation of the association in accordance with Part XVI of this Chapter.

Acts 1958, No. 125.

§354. Fees payable

Every non-profit funeral service association shall pay the following fees:

A. To the secretary of state:

1. For filing and recording articles, twenty-five cents per one hundred words.
2. For certificate of recordation, one dollar.

B. To the commissioner of insurance:

1. For each certificate of authority, twenty-five dollars.
2. For each examination, not exceeding twenty-five dollars per diem and expenses for each examiner.
3. Each agent's license, two dollars.

Acts 1958, No. 125.

§355. Exemption from taxation

All non-profit funeral service associations operating hereunder are declared to be charitable and beneficial institutions and they as well as all of their receipts, funds, reserves and all of their property, except real estate, used in connection with the operation of their affairs shall be exempted from any and all forms of taxation, except the fees prescribed in R.S. 22:354, by the state or any of its political subdivisions.

Acts 1958, No. 125.

§356. Penalties

A. Any person who shall solicit any application for or issue or cause to be issued any policy or membership certificate of any association within the provisions of this Part without a certificate of authority having been procured by such association from the commissioner of insurance or after such certificate has expired or become suspended or revoked, or any person representing himself to be an agent without having been duly licensed as hereinabove provided, shall be deemed guilty of a misdemeanor and upon conviction shall be fined not more than five hundred dollars or be imprisoned for not more than three months or both at the discretion of the court.

B. Any officer, director or agent of any association embraced within the provisions of this Part who shall wilfully:

(1) Solicit or receive any application which does not comply with the first two paragraphs of R.S. 22:336; or

(2) Fail to retain the original applications for policies as required by the third paragraph of R.S. 22:336; or

(3) Issue any policy which does not comply with R.S. 22:337; or

(4) Fail to maintain the reserve fund required by R.S. 22:343; or

(5) Withdraw or use any funds of such association in any other manner than is herein specifically authorized; or

(6) Issue any policy or make or cause to be made any assessment not provided for or authorized by R.S. 22:345; or

(7) Fail to maintain books or records as required by R.S. 22:348; or

(8) Refuse to any duly authorized representative of the office of the commissioner of insurance access to the books and records of the association; or

(9) Fail to file or fail to file within the required time the reports required by R.S. 22:350; or

(10) Make or cause to be made any assessment without a certificate of authority having been secured from the commissioner of insurance or after such certificate has expired or become suspended or revoked; or

(11) Make or cause to be made any assessment for any death which occurred prior to the date as of which any previous assessment was made as shown by the statement and list accompanying such previous assessment; or

(12) Fail to furnish with any assessment a statement of the receipts and disbursements of the previous assessment and list of the names of the policyholders who have died since the previous assessment and the value or amount of benefit furnished each; or

(13) Fail to include in any assessment any policyholder who has received a policy more than sixty days prior to such assessment; and any officer, director or agent of any such association who shall wilfully condone or acquiesce in any of said acts, shall be deemed guilty of a misdemeanor and upon conviction shall be fined not more than one thousand dollars or be imprisoned for not more than 6 months or both at the discretion of the court.

C. Any person who at one time holds or is named as the beneficiary in more than one policy of any association embraced within the provisions of this Part; or who at one time holds or is named as the beneficiary in policies of more than one association embraced within the provisions of this Part shall in addition to incurring the penalty of the nullity of that one of the policies which was subsequently issued, forfeit all fees or assessments paid on account of such subsequently issued policy.

D. The treasurer of any association who shall wilfully and without reasonable cause make any assessment on account of the death of any person who died prior to the date as of which the previous assessment was made as indicated by the statement of the receipts and disbursements of such previous assessment, the surety on his bond and any officer, director of any such association or any other persons who shall wilfully condone or acquiesce in such conduct, shall be liable in solido to the association at the instance of any policyholder for the amount of the benefit paid for such decedent.

Acts 1958, No. 125.

PART X. LIFE, HEALTH AND ACCIDENT INSURERS ON THE CO-OPERATIVE OR ASSESSMENT PLAN

§391. Continuance of present insurers

All life, health and accident insurers on co-operative or assessment plan organized and authorized to do business in this state as of 12:00 noon of October 1, 1948, may continue to operate provided, that from and after December 31, 1950, all policies issued by such insurers shall be subject to and in accordance with the laws and regulations of this state relative to industrial life insurance, and especially subject to the provisions of this Code relative to domestic industrial insurers, with the same insuring powers which they have on such date. The operation of such insurers shall be governed by the provisions of this Part, and by all the applicable provisions of this Code not in conflict herewith.

Acts 1958, No. 125.

§392. Future organization and qualification prohibited

No such insurer may be organized, and no alien or foreign insurer may be qualified to do business in this state after 12:00 noon of October 1, 1948.

Acts 1958, No. 125.

§393. Life, health and accident insurance on the assessment plan defined

A. Any domestic insurer, which issues any certificate, policy or other evidence of interest to, or makes any promise or agreement with its members whereby, upon the decease of a member, any money or other benefit is to be paid or provided by such insurer to the beneficiary designated by him, which money or other benefit is derived from voluntary donations or from admission fees, dues or assessments, or any of them, collected or to be collected from the members thereof, or members of a class therein or accumulation thereof, and wherein the money or other benefit so realized is applied to or accumulated for the uses and purposes herein specified of such insurer, and to the expenses of management and the prosecution of its business, shall be deemed to be engaged in the business of life insurance upon the co-operative or assessment plan, whether or not its certificates or policies, etc., are issued to persons engaged in a particular trade or occupation, and shall be subject to the provisions of this Part.

B. Any insurer which issues any certificate, policy or other evidence of interest to, or makes any promise or agreement with its members whereby, upon the sickness or other physical disability of a member, any money or other benefit is to be paid or provided by such insurer to such member or beneficiary designated by him, which money or other benefit is derived from voluntary donations or from admission fees, dues or assessments, or any of them, collected or to be collected from the members thereof, or members of a class therein, and wherein the money or other benefit is applied to or accumulated for the uses and purposes herein specified of such insurer, and to the expenses of management and the prosecution of its business, shall be deemed to be engaged in the business of health and accident insurance upon the co-operative or assessment plan, whether or not its certificates or policies, etc., are issued to persons engaged in a particular trade or occupation, and shall be subject to the provisions of this Part.

Acts 1958, No. 125.

§394. Deposit requirement

All domestic insurers operating under the provisions of this Part shall deposit with the commissioner of insurance a safekeeping or trust receipt from a bank doing business within this state indicating that twenty-five thousand dollars in money or approved bonds of the United States, the state of Louisiana, or any political subdivision thereof, of the par value of not less than twenty-five thousand dollars has been deposited; which deposit shall be held subject to the claim of any judgment creditor arising and accruing by virtue of any policy or certificate issued by such insurer, through judgment obtained against it in any court of this state or in any federal court in this state.

Acts 1958, No. 125. Amended by Acts 1981, No. 856, §1.

§395. Annual report

Insurers operating under the provisions of this Part shall file an annual report in accordance with the provisions of R.S. 22:1451.

Acts 1958, No. 125.

§396. Policy limits; required provisions

No policy issued by any insurer under this Part shall exceed five thousand dollars, and no one individual shall be issued policies of life and/or accident and health by any such insurer, in an aggregate amount of more than five thousand dollars. Every policy or certificate hereafter issued by any insurer authorized under this Part, shall have plainly written in red ink on the first page thereof the words "Assessment Plan" and shall specify the sum of money which it promises to pay upon each contingency insured against, which shall not be in excess of five thousand dollars, and the number of days after receipt of proof of the happening of such contingency in which such payment shall be made. Upon the occurrence of such contingency, unless the contract shall have been voided by fraud, or by breach of its conditions, the insurer shall be obligated to the beneficiary for such payment at the time and to the maximum amount specified in the policy or certificate. If the commissioner of insurance shall be satisfied upon investigation that any such insurer has refused or failed to make such payment for thirty days after it became due, and after proper demand, he shall notify the insurer to issue no new policies or certificates until such indebtedness is fully paid; and no officer or agent of such insurer shall make, sign or issue any policy or certificate of insurance while such notice is in force.

Every policy or certificate issued subsequent to 12:00 noon of October 1, 1948, by any insurer authorized under this Part shall contain a clause reserving the right to the insurer to increase the rate of dues or assessments, or to levy additional assessments against the insured, to the extent necessary to pay his respective share of losses in case the mortuary fund shall become depleted. All the proceeds of such increase in assessments or additional assessments shall be placed in their entirety to the credit of the mortuary fund, and no part thereof shall be used for the expenses of management.

Acts 1958, No. 125.

§397. Expense funds; mortuary funds

The salaries or remunerations of officers, agents, representatives, employees and attorneys of such insurer and the expenses of management, shall be limited to the aggregate amount in one year of not more than thirty-three and one-third per cent of the cash income actually received by it from premiums, assessments, dues, membership fees or reinstatement fees for such one year, except that the full first year premium, assessment, dues or membership fee on new policies may be used for expenses of management. The remaining sixty-six and two-thirds per cent of the income received and the accretions thereon, shall be placed in a mortuary fund, which shall be used for the payment of policy benefits only, provided that, at the option of the insurer, state, parish and municipal taxes and insurance department fees may be paid for from this fund.

Acts 1958, No. 125.

PART X-A. LIMITATIONS ON ASSIGNMENT OF OBLIGATIONS

§421. Definitions

For purposes of this Part, the following definitions shall apply:

(1) "Carve-out agreement" means a written agreement between a health insurance issuer and another entity to provide health care services other than medical, surgical, or physician services, including but not limited to an agreement to provide prescription drugs, mental health or substance abuse treatment services, or services of clinicians other than physicians licensed to practice medicine, other than as incidental to the provision of the foregoing carve-out services.

(2) "Health insurance coverage" means benefits consisting of medical care provided or arranged for directly, through insurance or reimbursement, or otherwise, and includes health care services paid for under any plan, policy, or certificate of insurance.

(3) "Health insurance issuer" means an insurance company, including a health maintenance organization as defined and licensed pursuant to Part XII of Chapter 2 of this Title, unless preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974.

Added by Acts 2004, No. 417, §1.422. Assignment of obligations limited

A. When a health insurance issuer contracts or subcontracts with another entity for the provision of services, the health insurance issuer shall be ultimately responsible for compliance with the laws and regulations governing risk-based capital (R.S. 22:2036.1 et seq.), prompt payment of claims (R.S. 22:250.31 et seq,), and medical necessity review (R.S. 22:3070 et seq.).

B. This Part shall not apply to health insurance coverage for services under the terms of a carve-out agreement. Nor does this Part apply to health insurance coverage or services provided pursuant to the terms of a contract with the federal government or any agency thereof, including but not limited to the Medicare Advantage program.

C. Nothing herein shall prohibit or restrict a health insurance issuer from establishing payment arrangements, including but not limited to capitated payment arrangements, with health care providers or other entities in which financial risk is contractually delegated and assumed.

D. Nothing herein shall prohibit or restrict a health insurance issuer from entering into an agreement with a health care provider or other entity to which financial risk is delegated in which such provider or entity is contractually responsible to the health insurance issuer for compliance with requirements specified in R.S. 22:250.31 et seq. and R.S. 22:3070 et seq., including financial penalties.

E. Nothing herein shall prohibit or restrict a health insurance issuer or a health care provider or other entity to which financial risk is delegated from entering into contractual agreements with a health care provider rendering health care services in which the provider rendering services agrees to seek reimbursement only from the provider or entity that has assumed the delegated financial risk from the health insurance issuer.

F. The Department of Insurance is authorized to adopt rules and regulations needed to implement the provisions of this Part.

Added by Acts 2004, No. 417, §1.

PART XI. RECIPROCAL INSURERS

§431. Scope of part

A. This Part shall apply to all reciprocal insurers organized or authorized to transact business in this state.

B. As used in this Part "subscriber" means the participant or policyholder; "attorney-in-fact" means the representative of the subscribers through whom reciprocal insurance is exchanged; "reciprocal insurer" means the organization or group of all the subscribers.

Acts 1958, No. 125.

§432. Subscribers

Any person, partnership, private corporation, board, association, estate, trustee, or fiduciary may be a subscriber of a reciprocal insurer. All reciprocal or inter-insurance contracts exchanged among such subscribers shall be executed by an attorney-in-fact common to all subscribers.

Acts 1958, No. 125.

§433. Name; suits

A reciprocal insurer shall:

(1) Have and use a business name, which shall include the words "Reciprocal" or "Inter-Insurance Exchange" or "Underwriters" or "Underwriting" or be supplemented by the words "A Reciprocal" or "An Inter-Insurance Exchange." Such name shall not be the same as or deceptively similar to the name of any other insurer organized or authorized to transact business in this state.

(2) Sue and be sued in its own name.

Acts 1958, No. 125.

§434. Insuring powers

A. A reciprocal insurer may be authorized to exchange contracts covering any kind or kinds of insurance defined by this Code, other than life or title insurance.

B. A reciprocal insurer may purchase reinsurance upon the risk of any subscriber, and may grant reinsurance as to any kind of insurance which it is authorized to transact direct.

Acts 1958, No. 125.

§435. Minimum application and surplus requirements

A. A domestic reciprocal insurer, if it has otherwise complied with the provisions of this Code, may be authorized to exchange contracts of insurance in this state upon qualifying therefor and by having initial minimum assets as follows:

	Initial Insurance	Minimum Surplus
(1)	Health and accident	$ 300,000
(2)	Vehicle physical damage	250,000
(3)	Title	75,000
(4)	Industrial fire	300,000
(5)	Any company organized and authorized to transact worker's compensation only as of July 27, 1966	150,000
(6)	Any company organized and authorized to transact crop and livestock insurance only as of July 27, 1966	250,000
(7)	Vehicle	1,000,000
(8)	Liability	1,000,000
(9)	Worker's compensation	1,000,000
(10)	Burglary and forgery	1,000,000
(11)	Glass	1,000,000
(12)	Fidelity and surety	1,000,000
(13)	Fire and extended coverage	1,000,000
(14)	Steam boiler and sprinkler leakage	1,000,000
(15)	Crop and livestock	1,000,000
(16)	Marine and transportation	1,000,000
(17)	Miscellaneous	1,000,000
(18)	All insurances, except life and title	1,000,000

For the purpose of this Section, vehicle physical damage insurance shall be defined as insurance against loss or damage to any land vehicle or property while contained therein or thereon or being loaded or unloaded therein or therefrom.

B. Insurers already organized and qualified under the laws of this state as of July 27, 1966 shall continue to have the same underwriting powers they had as of that date, provided all such insurers shall increase the surplus requirements to the amounts set out in Subsection A of this Section 435 on or before August 1, 1967.

Acts 1958, No. 125. Amended by Acts 1958, No. 102, §1; Acts 1962, No. 50, §1; Acts 1966, No. 72, §1; Acts 1983, 1st Ex.Sess., No. 1, §6.

§436. REPEALED BY ACTS 1966, No. 72, §2

§437. Power of attorney

A. The rights and powers of the attorney-in-fact of a reciprocal insurer shall be as provided in the power of attorney or other authority of the attorney-in-fact given it by the subscribers, which shall be set forth:

(1) The powers of and the general services to be performed by the attorney-in-fact.

(2) The address of the principal office of the attorney-in-fact.

(3) That the attorney-in-fact is authorized to accept service of process on behalf of the reciprocal insurer and to authorize the secretary of state or some other person in his office during his absence he may designate to receive service of process in actions against the insurer upon contracts exchanged.

(4) The maximum amount to be deducted from advance premiums or deposits to be paid to the attorney-in-fact and the items of expense, in addition to losses, to be paid by the reciprocal.

(5) A provision for a cash premium or deposit.

(6) Except as to non-assessable policies, a provision for a contingent several liability of each subscriber in an amount of not less than one nor more than ten times the cash premium or deposit stated in the contract.

(7) Any other lawful provisions deemed advisable.

B. The terms of any power of attorney or agreement collateral thereto shall be reasonable and equitable, and no such power or agreement or any amendment thereof shall be used or be effective in this state until approved by the commissioner of insurance.

Acts 1958, No. 125.

§438. Declaration of organization

The attorney-in-fact of subscribers who desire to form a reciprocal insurer under this Part shall sign and acknowledge, before an officer authorized to take acknowledgments, a declaration of organization setting forth:

(1) The name of the reciprocal insurer and the attorney-in-fact.

(2) The location of the insurer's principal office, which shall be the same as that of the attorney-in-fact, and shall be maintained within this state.

(3) The kinds of insurance proposed to be transacted.

(4) The names and addresses of the officers and directors of the attorney-in-fact, if a corporation, or of its members, if a firm.

(5) The minimum and maximum liability of the subscriber for the payment of losses occurring under its policies.

(6) Any other lawful provisions deemed advisable.

Acts 1958, No. 125.

§439. Documents to be filed

Upon execution of the declaration of organization, there shall be filed with the commissioner of insurance the following:

(1) The declaration of organization.

(2) A copy of the power of attorney of the attorney-in-fact under or by virtue of which insurance contracts are to be effected or exchanged.

(3) The insurer's irrevocable authorization of the secretary of state, and his successors in office, to receive legal process issued in this state against the insurer.

(4) All forms of insurance policies or contracts and endorsements proposed to be used and the forms of applications therefor.

(5) Two organization bonds, or the cash or securities provided for in R.S. 22:440.

Upon approval of the commissioner of insurance, he shall record with the secretary of state Items 1, 2 and 3 enumerated in this Section.

Acts 1958, No. 125.

§440. Organization bonds

A. The attorney-in-fact shall deliver to the commissioner of insurance two bonds in favor of the state of Louisiana, in the penal sum of ten thousand dollars each, with the attorney-in-fact as principal and a duly authorized surety insurer as surety. One of such bonds shall be conditioned upon the payment of costs incurred by the state by reason of any legal proceedings for the liquidation or dissolution of the reciprocal insurer prior to the issuance to it of a certificate of authority to do an insurance business. The other bond shall be for the use and benefit of subscribers and creditors, and shall be conditioned upon the full and complete accounting for all funds and property coming into the possession of the attorney-in-fact prior to the issuance to the reciprocal insurer of a certificate of authority to do an insurance business.

B. In lieu of delivering the above bonds, the attorney-in-fact may deposit with the commissioner of insurance twenty thousand dollars in cash or securities of the United States government or of the state of Louisiana, having a market value of at least twenty thousand dollars. The cash or securities so deposited shall be held in trust by the commissioner of insurance, until the issuance of a certificate of authority to the insurer, to indemnify the state of Louisiana and all subscribers and creditors of the insurer for the same matters and things set forth as conditions of the organization bonds mentioned in Sub-section B.

Acts 1958, No. 125.

§441. Authority to solicit applications

If the commissioner of insurance finds that the documents required to be filed with him are in conformity with law, he shall approve such documents and issue to the attorney-in-fact a permit, which shall expire at the end of one year from its date, authorizing the attorney-in-fact to solicit applications, advance premiums and deposits for insurance in accordance with this Code on the form of application for insurance filed with him, and to do such other acts as may be necessary and proper in order to complete the organization of the reciprocal insurer and to entitle it to receive a certificate of authority to transact an insurance business.

Acts 1958, No. 125.

§442. Deposit

Each domestic reciprocal insurer shall make and maintain with the commissioner of insurance a safekeeping or trust receipt from a bank doing business in this state indicating that a deposit of cash or approved securities has been made in an amount required by Part XXII of Title 22 of the Louisiana Revised Statutes of 1950.

Acts 1958, No. 125. Amended by Acts 1981, No. 856, §1.

§443. Certificate of authority

When the commissioner of insurance has been notified that the required bona fide applications have been received and that the reciprocal insurer has received from each subscriber the full annual premium or premium deposit required for each policy applied for and has on hand the initial surplus provided in R.S. 22:435, or, in lieu of these requirements, that the minimum surplus provided in R.S. 22:436 if it is to transact one kind of business only is on hand, he shall conduct an examination of the insurer. If he finds that the organization is complete, and that all of the requirements of the Code have been met, he shall issue to the attorney-in-fact a certificate of authority in the name of the insurer to transact the kind or kinds of business specified therein. No attorney-in-fact shall transact any business of insurance until the certificate of authority has been received nor any business not specified in such certificate of authority.

Acts 1958, No. 125.

§444. Policies effective

Any policy applied for by an original subscriber shall become effective upon the issuance of the certificate of authority to the reciprocal insurer.

Acts 1958, No. 125.

§445. Subscribers' liability

A. Except as to non-assessable policies, any contract of insurance exchanged pursuant to this Part shall provide for a contingent several liability of the subscriber for payment of actual losses and expenses incurred while such contract was in force. Such contingent liability shall be in an amount as specified in the declaration of organization.

B. Each assessable policy issued by the insurer shall plainly set forth a statement of the contingent liability.

C. The contingent liability of each subscriber for the obligations of the reciprocal insurer shall not be joint, but shall be individual and several.

Acts 1958, No. 125.

§446. Non-assessable contracts

Except as provided in R.S. 22:436, any domestic reciprocal insurer authorized so to do by its declaration of organization may issue policies without contingent liability of the subscriber for assessment upon approval of the commissioner of insurance and upon compliance with the following requirements:

(1) It shall have and at all times maintain a surplus as determined from its last annual statement, which is at least equal to the minimum capital and the paid in surplus required on organization of a domestic stock insurer organized under the provisions of this Code.

(2) It shall have submitted a copy of its proposed non-assessable policy or policies for approval of the commissioner of insurance and shall have obtained his approval thereof.

Acts 1958, No. 125.

§447. Contributed surplus

The attorney-in-fact or subscribers of a reciprocal insurer may make contributions to surplus under agreements approved by the commissioner of insurance which may provide for the payment of interest not exceeding eight per cent per annum and shall provide that the contributions and interest thereon shall be repaid only out of the surplus of such insurer in excess of the original surplus required of such insurer by R.S. 22:435. Such excess of surplus shall be calculated upon the fair market value of the assets of the insurer, and any contributions to surplus shall constitute and be enforceable as a liability of the insurer only as against such excess of surplus. Any unpaid balance of such contributions to surplus shall be reported in the annual statement to be filed with the commissioner of insurance and no part of such contributions shall be repaid to the contributors, except under such terms and in such circumstances as are approved by the commissioner of insurance.

Acts 1958, No. 125.

§448. Process

A. Legal process may be served upon such insurer by service upon the insurer's attorney-in-fact at the principal office of the attorney-in-fact or by service upon the secretary of state. Service of process upon an individual subscriber shall not constitute service upon the insurer.

B. When such process is served upon the secretary of state duplicate copies of such process shall be delivered to him and he shall immediately forward one copy of such process to the insurer's attorney-in-fact, by registered mail with return receipt requested, postage prepaid, giving the day and hour of such service.

Acts 1958, No. 125.

§449. Share in savings

A reciprocal insurer may from time to time return to its subscribers any savings or credits accruing to their accounts. Any such distribution shall not unfairly discriminate between classes of risks, or policies, or between subscribers.

Acts 1958, No. 125.

§450. Subscribers' account

The attorney-in-fact, in addition to the books of account of the reciprocal, shall keep and maintain a separate account for each individual subscriber, setting forth therein the date or periods of the subscriber's participation in the exchange of insurance, the subscriber's deposits, the savings returned to the subscriber and such other information as may be necessary for the determination of the subscriber's proportionate share, if any, of the surplus funds of the reciprocal insurer in case of liquidation. The attorney-in-fact shall not be required to file a list of the subscribers with the commissioner of insurance.

Acts 1958, No. 125.

§451. Annual statements

The annual statement of a reciprocal insurer shall be made and filed by the attorney-in-fact.

Acts 1958, No. 125.

§452. Reserves

Each reciprocal insurer subject to this Part shall maintain the same reserves, calculated in the same manner and upon the same basis as the reserves required to be maintained by stock and mutual insurers transacting the same kind or kinds of insurance.

Acts 1958, No. 125.

§453. Amendment of declaration of organization

The attorney-in-fact of any domestic reciprocal insurer upon written approval of at least a majority of the subscribers, may amend the declaration of organization of such insurer in any respect not in violation of law, but the declaration of organization may not be amended to include any provision prohibited, or to delete any provision required in the original organization of the insurer under this Code. Any amendment to the declaration of organization shall be signed and acknowledged by the attorney-in-fact, approved by the commissioner of insurance and filed with the secretary of state in the same manner as the original declaration of organization. If the commissioner of insurance finds such amendment to be in conformity with law, he shall endorse his approval thereon and the amendment shall be recorded in the manner provided in R.S. 22:439.

Acts 1958, No. 125.

§454. Application for receiver, etc.

No proceedings for the dissolution of, or the appointment of a receiver for, any domestic reciprocal insurer shall be entertained by any court in this state unless the same is made by the commissioner of insurance in accordance with Part XVI of this Chapter.

Acts 1958, No. 125.

§455. Penalties

No person shall act as attorney-in-fact for a reciprocal insurer except in accordance with the provisions of this Part and any person who violates any of the provisions of this Section or who knowingly participates in or abets such violation shall be guilty of a misdemeanor and upon conviction thereof shall be fined not less than one hundred dollars nor more than one thousand dollars.

Acts 1958, No. 125.

§456. Application of other sections

Except as otherwise provided in this Part, every reciprocal insurer shall be subject to other applicable provisions of this Code.

Acts 1958, No. 125.

PART XII. LLOYD'S PLAN INSURERS

§491. REPEALED BY ACTS 2004, No. 513, §1.
§492. REPEALED BY ACTS 2004, No. 513, §1.
§493. REPEALED BY ACTS 2004, No. 513, §1.
§494. REPEALED BY ACTS 2004, No. 513, §1.
§495. REPEALED BY ACTS 2004, No. 513, §1.
§496. REPEALED BY ACTS 2004, No. 513, §1.
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§506. REPEALED BY ACTS 2004, No. 513, §1.
§507. REPEALED BY ACTS 2004, No. 513, §1.

PART XIII. FRATERNAL BENEFIT SOCIETIES

§541. Fraternal benefit societies

A fraternal benefit society is any incorporated society, order, or supreme lodge, without capital stock, including one exempted under the provisions of R.S. 22:578(A)(2), whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which provides benefits in accordance with this Part.

Acts 1958, No. 125; Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§542. Lodge system defined

A. A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated, or admitted in accordance with its laws, rules, and ritual. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once each month in furtherance of the purposes of the society.

B. A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of such children, nor shall they have a voice or vote in the management of the society.

Acts 1958, No. 125; Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§543. Representative form of government defined

A. A society has a representative form of government when all of the following requirements are met:

(1) It has a supreme governing body constituted in one of the following ways:

(a) Assembly. The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number of the total delegates, and shall not have less than a majority of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected, shall meet at least once every four years, and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws.

(b) Direct Election. The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws. A society may provide for election of the board by mail. Each term of a board member shall not exceed four years. Vacancies on the board between elections shall be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society.

(2) The officers of the society are elected either by the supreme governing body or by the board of directors.

(3) Only benefit members are eligible for election to the supreme governing body, the board of directors, or any intermediate assembly.

(4) Each voting member shall have one vote; no vote shall be cast by proxy.

Acts 1958, No. 125; Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§544. General definitions

As used in this Part, the following terms shall have the meanings herein given to each unless the context clearly indicates otherwise:

(1) "Benefit contract" means the agreement for provision of benefits authorized by R.S. 22:556, as that agreement is described in R.S. 22:559(A).

(2) "Benefit member" means an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract.

(3) "Certificate" means the document issued as written evidence of the benefit contract.

(4) "Laws" means the society's articles of incorporation, constitution, and bylaws, however designated.

(5) "Lodge" means subordinate member units of the society, known as camps, courts, councils, branches, or by any other designation.

(6) "Premiums" means premiums, rates, dues, or other required contributions by whatever name known, which are payable under the certificate.

(7) "Rules" means all rules, regulations, or resolutions adopted by the supreme governing body or board of directors which are intended to have general application to the members of the society.

(8) "Society" means fraternal benefit society.

Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§545. Purposes and powers

A. A society shall operate for the benefit of members and their beneficiaries by:

(1) Providing benefits as specified in R.S. 22:556.

(2) Operating for one or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic, or religious purposes for the benefit of its members, which may also be extended to others. Such purposes may be carried out directly by the society, or indirectly through subsidiary corporations or affiliated organizations.

B. Every society shall have the power to adopt laws and rules for the government of the society, the admission of its members, and the management of its affairs. It shall have the power to change, alter, add to, or amend such laws and rules and shall have such other powers as are necessary and incidental to carry into effect the objects and purposes of the society.

Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§546. Qualifications for membership

A. A society shall specify in its laws or rules:

(1) Eligibility standards for each class of membership, provided that if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than age fifteen and not greater than age twenty-one.

(2) The process for admission to membership for each membership class.

(3) The rights and privileges of each membership class, provided that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

B. A society may also admit social members who shall have no voice or vote in the management of the insurance affairs of the society.

C. Membership rights in the society are personal to the member and are not assignable.

Acts 1958, No. 125. Amended by Acts 1972, No. 768, §7; Acts 1987, No. 470, eff. Jan. 1, 1988.

§547. Location of office, meetings, communications to members, grievance procedures

A. The principal office of any domestic society shall be located in this state. The meetings of its supreme governing body may be held in any state, district, province, or territory wherein such society has at least one subordinate lodge, or in such other location as determined by the supreme governing body, and all business transacted at such meetings shall be as valid in all respects as if such meetings were held in this state. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

B.(1) A society may provide in its laws for an official publication in which any notice, report, or statement required by law to be given to members, including notice of election, may be published. Such required reports, notices, and statements shall be printed conspicuously in the publication. If the records of a society show that two or more members have the same mailing address, an official publication mailed to one member is deemed to be mailed to all members at the same address unless a member requests a separate copy.

(2) Not later than June first of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society or, in lieu thereof, such synopsis may be published in the society's official publication.

C. A society may provide in its laws or rules for grievance or complaint procedures for members.

Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§548. No personal liability

A. The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

B.(1) Any person who, by reason of the fact that he is or was a director, officer, employee, or agent of any society or of any firm, corporation, or organization which he served in any capacity at the request of any society, incurs reasonable expenses or the imposition of liabilities, or both, arising out of any action, suit, or proceeding, whether civil, criminal, administrative, or investigative, or threat thereof, may be indemnified and reimbursed by that society for such expenses and liabilities. A person shall not be so indemnified or reimbursed in relation to any matter in such action, suit, or proceeding as to which he shall finally be adjudged to be or has been guilty of breach of a duty as a director, officer, employee, or agent of the society, or in relation to any matter in such action, suit, or proceeding, or threat thereof, which has been made the subject of a compromise settlement, unless in either such case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, had no reasonable cause to believe that his conduct was unlawful.

(2) The determination whether the conduct of such person met the standard required in order to justify indemnification and reimbursement in relation to any matter described may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to such action, suit, or proceeding or by a court of competent jurisdiction. The termination of any action, suit, or proceeding by judgment, order, settlement, conviction, or upon a plea of no contest, as to such person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement. The foregoing right of indemnification and reimbursement shall not be exclusive of other rights to which such person may be entitled as a matter of law and shall inure to the benefit of his heirs, executors, and administrators.

C. A society shall have the power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the society, or who is or was serving at the request of the society as a director, officer, employee, or agent of any other firm, corporation, or organization against any liability asserted against such person and incurred by him in any such capacity or arising out of his status as such, whether the society would have the power to indemnify the person against such liability under this Section.

Acts 1958, No. 125; Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§549. Waiver

The laws of the society may provide that no subordinate body, nor any of its subordinate officers or members, shall have the power or authority to waive any of the provisions of the laws of the society. Such provision shall be binding on the society and every member and beneficiary of a member.

Acts 1958, No. 125; Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§550. Organization

A domestic society organized on or after the effective date of this Part shall be formed as follows:

(1) Seven or more citizens of the United States, a majority of whom are citizens of this state, who desire to form a fraternal benefit society, may execute by authentic act or by private act duly acknowledged articles of incorporation, in which shall be stated:

(a) The proposed corporate name of the society, which shall not so closely resemble the name of any other society or insurance company as to be misleading or confusing.

(b) The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this Part.

(c) The names and resident addresses of the incorporators and the names, resident addresses, and official titles of all the officers, trustees, directors, or other persons who are to exercise general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than one year from the date of issuance of the permanent certificate of authority.

(2) The articles of incorporation, certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor, and circulars to be issued by the society and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one year shall be filed with and approved by the commissioner of insurance, who may require such further information as the commissioner deems necessary. The articles of incorporation, bylaws, and rules shall also be filed with the secretary of state. The bond with sureties approved by the commissioner of insurance shall be in such amount, but not less than three hundred thousand dollars nor more than one million five hundred thousand dollars, as required by the commissioner of insurance of which the minimum must be maintained if the association is to maintain its certificate of authority. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this Part and all provisions of the law have been complied with, the commissioner of insurance shall so certify, and the secretary of state shall file the articles of incorporation in the manner provided in R.S. 22:34. The commissioner of insurance shall furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

(3) No preliminary certificate of authority granted under the provisions of this Section shall be valid after one year from its date or after such further period, not exceeding one year, as may be authorized by the commissioner of insurance upon cause shown, unless the five hundred applicants hereinafter required have been secured and the organization has been completed as provided herein. The articles of incorporation and all other proceedings thereunder shall become null and void in one year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as provided hereinafter.

(4) Upon receipt of a preliminary certificate of authority from the commissioner of insurance, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount so collected. No society shall incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, or allow, or offer or promise to pay or allow, any benefit to any person until all of the following conditions are met:

(a) Actual bona fide applications for benefits have been secured on not less than five hundred applicants, and any necessary evidence of insurability has been furnished to and approved by the society.

(b) At least ten subordinate lodges have been established into which the five hundred applicants have been admitted.

(c) There has been submitted to the commissioner of insurance, under oath of the president or secretary, or corresponding officer of the society, a list of such applicants, giving their names and addresses, the date each was admitted, the name and number of the subordinate lodge of which each applicant is a member, the amount of benefits to be granted and the premiums collected therefor.

(d) It shall have been shown to the commissioner of insurance, by sworn statement of the treasurer, or corresponding officer of such society, that at least five hundred applicants have each paid in cash at least one regular monthly premium as herein provided, which premiums in the aggregate shall amount to at least one hundred and fifty thousand dollars. The advance premiums shall be held in trust during the period of organization and if the society has not qualified for a certificate of authority within one year, as provided herein, the premiums shall be returned to said applicants.

(5) The commissioner of insurance may make such examination and require such further information as the commissioner deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the commissioner shall issue to the society a certificate of authority to that effect and that the society is authorized to transact business pursuant to the provisions of this Part. The certificate of authority shall be prima facie evidence of the existence of the society at the date of issuance of such certificate. The commissioner of insurance shall cause a record of the certificate of authority to be made. A certified copy of such record may be given in evidence with like effect as the original certificate of authority.

(6) Any incorporated society authorized to transact business in this state at the time this Part becomes effective shall not be required to reincorporate. Any voluntary fraternal benefit association existing on such date may incorporate hereunder.

Acts 1958, No. 125; Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§551. Amendments to laws

A. A domestic society may amend its laws in accordance with the provisions thereof by action of its supreme governing body at any regular or special meeting thereof or, if its laws so provide, by referendum. Such referendum may be held in accordance with the provisions of its laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members, or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six months from the date of submission thereof, a majority of the members voting shall have signified their consent to such amendment by one of the methods herein specified.

B. No amendment to the laws of any domestic society shall take effect unless approved by the commissioner of insurance who shall approve such amendment if he finds that it has been duly adopted and is not inconsistent with any requirement of the laws of this state or with the character, objects, and purposes of the society. Unless the commissioner of insurance disapproves any such amendment within sixty days after the filing of same, the amendment shall be considered approved. The approval or disapproval of the commissioner of insurance shall be in writing and mailed to the secretary or corresponding officer of the society at its principal office. In case the commissioner disapproves the amendment, the reasons therefor shall be stated in the written notice. Within ninety days after approval by the commissioner of insurance a certified copy of the amendment shall be filed with the secretary of state.

C. Within ninety days after the approval thereof by the commissioner of insurance, all such amendments, or a synopsis thereof, shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that they have been duly addressed and mailed, shall be prima facie evidence that such amendments, or synopsis thereof, have been furnished the addressee.

D. Every foreign or alien society authorized to do business in this state shall file with the commissioner of insurance and the secretary of state a duly certified copy of all amendments of, or additions to, its laws within ninety days after enactment.

E. Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society shall be prima facie evidence of the legal adoption thereof.

Acts 1958, No. 125; Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§552. Institutions

A society may create, maintain and operate, or may establish organizations to operate, not for profit institutions to further the purposes permitted by R.S. 22:545(A)(2). Such institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held, or leased by the society for this purpose shall be reported in every annual statement.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§553. Reinsurance

A. A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer, other than another fraternal benefit society, having the power to make such reinsurance and authorized to do business in this state, or if not so authorized, one which is approved by the commissioner of insurance, but no such society may reinsure substantially all of its insurance in force without the written permission of the commissioner of insurance. It may take credit for the reserves on such ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability, to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after the effective date of this Part, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contractor contracts reinsured without diminution because of the insolvency of the ceding society.

B. Notwithstanding the limitation in Subsection A of this Section, a society may reinsure the risks of another society in a consolidation or merger approved by the commissioner of insurance under R.S. 22:554.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§554. Consolidations and mergers

A. A domestic society may consolidate or merge with any other society by complying with the provisions of this Section. It shall file with the commissioner of insurance the following documents:

(1) A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger.

(2) A sworn statement by the president and secretary or corresponding officers of each society showing the financial condition thereof on a date fixed by the commissioner of insurance but not earlier than December thirty-first, next preceding the date of the contract.

(3) A certificate of such officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds vote of the supreme governing body of each society, such vote being conducted at a regular or special meeting of each such body, or, if the society's laws permit, by mail.

(4) Evidence that at least sixty days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society.

B. If the commissioner of insurance finds that the contract is in conformity with the provisions of this Section, that the financial statements are correct and that the consolidation or merger is just and equitable to the members of each society, the commissioner shall approve the contract and issue a certificate to such effect, and said contract of consolidation or merger, upon being filed with the secretary of state, shall be in full force and effect unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In such event the consolidation or merger shall not become effective until it has been approved as provided by the laws of such state or territory and a certificate of such approval has been filed with the commissioner of insurance of this state or, if the laws of such state or territory contain no such provision, then the consolidation or merger shall not become effective until it has been approved by the commissioner of insurance of such state or territory and a certificate of such approval filed with the commissioner of insurance of this state.

C. Upon the consolidation or merger becoming effective as herein provided, all the rights, franchises, and interests of the consolidated or merged societies in and to every species of property, real, personal, or mixed, and things in action thereunto belonging shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument, except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest therein, vested under the laws of this state in any of the societies consolidated or merged, shall not revert or be in any way impaired by reason of the consolidation or merger, but shall vest absolutely in the society resulting from or remaining after such consolidation or merger.

D. The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that such notice or document has been duly addressed and mailed, shall be prima facie evidence that such notice or document has been furnished the addressees.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§555. Conversion of fraternal benefit society into mutual life insurance company

Any domestic fraternal benefit society may be converted and licensed as a mutual life insurance company by compliance with all the requirements of the Louisiana Insurance Code for mutual life insurance companies. A plan of conversion shall be prepared in writing by the board of directors setting forth in full the terms and conditions of conversion. The affirmative vote of two-thirds of all members of the supreme governing body at a regular or special meeting shall be necessary for the approval of such plan. No such conversion shall take effect until approved by the commissioner of insurance who may give such approval if the commissioner finds that the proposed change is in conformity with the requirements of law and not prejudicial to the certificate holders of the society.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§556. Benefits

A. A society may provide the following contractual benefits in any form:

(1) Death benefits.

(2) Endowment benefits.

(3) Annuity benefits.

(4) Temporary or permanent disability benefits.

(5) Hospital, medical or nursing benefits.

(6) Monument or tombstone benefits to the memory of deceased members.

(7) Such other benefits as authorized for life insurers and which are not inconsistent with this Part.

B. A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in Subsection A of this Section, consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§557. Beneficiaries

A. The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

B. A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expenses occasioned by the burial of the member.

C. If, at the death of any person insured under a benefit contract, there is no lawful beneficiary to whom the proceeds shall be payable, the amount of such benefit, except to the extent that funeral benefits may be paid as hereinbefore provided, shall be payable to the personal representative of the deceased insured, provided that if the owner of the certificate is other than the insured, such proceeds shall be payable to such owner.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§558. Benefits not attachable

No money or other benefit, charity, relief, or aid to be paid, provided or rendered by any society, shall be liable to attachment, garnishment, or other process, or to be seized, taken, appropriated, or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§559. The benefit contract

A. Every society authorized to do business in this state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided thereby. The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each thereof, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

B. Any changes, additions, or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate, shall bind the owner and the beneficiaries, and shall govern and control the benefit contract in all respects the same as though such changes, additions, or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition, or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

C. Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

D. A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of such deficiency as ascertained by its board, and that if the payment is not made it shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates or the owner may accept a proportionate reduction in benefits under the certificate, or both. The society may specify the manner of the election and which alternative is to be presumed if no election is made. This must be placed in bold print on the first page of the contract.

E. Copies of any of the documents mentioned in this Section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

F. No certificate shall be delivered or issued for delivery in this state unless a copy of the form has been filed with the commissioner of insurance in the manner provided for like policies issued by life insurers in this state. Every life, accident, health, or disability insurance certificate and every annuity certificate issued on or after one year from the effective date of this Part shall meet the standard contract provision requirements not inconsistent with the Part for like policies issued by life insurers in this state, except that a society may provide for a grace period for payment of premiums of one full month in its certificates. The certificate shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

G. Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control of ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and may provide in all other respects for the regulation, government, and control of such certificates and all rights, obligations, and liabilities incident thereto and connected therewith. Ownership rights prior to such transfer shall be specified in the certificate.

H. A society may specify the terms and conditions on which benefit contracts may be assigned.

Acts 1958, No. 125; Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§560. Nonforfeiture benefits, cash surrender values, certificate loans, and other options

A. For certificates issued prior to one year after the effective date of this Part, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall comply with the provisions of law applicable immediately prior to the effective date of this Part.

B. For certificates issued on or after one year from the effective date of this Part for which reserves are computed on the commissioner's 1941 Standard Ordinary Mortality Table, the commissioner's 1941 Standard Industrial Table or the commissioner's 1958 Standard Ordinary Mortality Table, or the commissioner's 1980 Standard Mortality Table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits based upon such tables.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§561. Investments

A society shall invest its funds only in such investments as are authorized by the laws of this state for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this state which invests its funds in accordance with the laws of the state, district, territory, country, or province in which it is incorporated, shall be held to meet the requirement of this Section for the investment of funds.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§562. Funds

A. All assets shall be held, invested, and disbursed for the use and benefit of the society, and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

B. A society may create, maintain, invest, disburse, and apply any special fund or funds necessary to carry out any purpose permitted by the laws of the society.

C. A society may, pursuant to resolution of its supreme governing body, establish and operate one or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers establishing such accounts and issuing such contracts. To the extent the society deems it necessary in order to comply with any applicable federal or state laws, or any rules issued thereunder, the society may adopt special procedures for the conduct of the business and affairs of a separate account, may for persons having beneficial interests therein provide special voting and other rights, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account, and may issue contracts on a variable basis to which R.S. 22:559(B) and (D) shall not apply.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§563. Exemptions

Except as herein provided, societies shall be governed by this Part and shall be exempt from all other provisions of the insurance laws of this state unless they be expressly designated therein, or unless it is specifically made applicable by this Part.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§564. Taxation

Every society organized or licensed under this Part is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from all state, parish, district, municipal, or school tax, other than taxes on real estate and office equipment.

Acts 1958, No. 125; Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§565. Valuation

A. Standards of valuation for certificates issued prior to one year after the effective date of this Part shall be those provided by the laws applicable immediately prior to the effective date of this Part.

B. The minimum standards of valuation for certificates issued on or after one year from the effective date of this Part shall be based on the following tables:

(1) For certificates of life insurance, the commissioner's 1941 Standard Ordinary Mortality Table, the commissioner's 1941 Standard Industrial Mortality Table, the commissioner's 1958 Standard Ordinary Mortality Table, the commissioner's 1980 Standard Ordinary Mortality Table or any more recent table made applicable to life insurers.

(2) For annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits, and for noncancellable accident and health benefits, such tables as are authorized for use by life insurers in this state.

C. All of the above shall be under valuation methods and standards, including interest assumptions, in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits.

D. The commissioner of insurance may, in his discretion, accept other standards for valuation if the commissioner finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard herein prescribed. The commissioner of insurance may, in his discretion, vary the standards of mortality applicable to all benefit contracts on substandard lives or other extra hazardous lives by any society authorized to do business in this state.

E. Any society, with the consent of the commissioner of insurance of the state of domicile of the society and under such conditions, if any, which the commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any benefit member shall not be affected thereby.

Acts 1958, No. 125; Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§566. Reports

Reports shall be filed in accordance with the provisions of this Section as follows:

(1) Every society transacting business in this state shall annually, on or before March first, unless for cause shown such time has been extended by the commissioner of insurance, file with the commissioner of insurance a true statement of its financial condition, transactions, and affairs for the preceding calendar year. The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner of insurance.

(2) As part of the annual statement herein required, each society shall, on or before March first, file with the commissioner of insurance a valuation of its certificates in force on December thirty-first of this year preceding, provided the commissioner of insurance may, in his discretion for cause shown, extend the time for filing such valuation for not more than two calendar months. The valuation shall be done in accordance with the standards specified in R.S. 22:565. The valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

(3) A society neglecting to file the annual statement in the form and within the time provided by this Section shall forfeit one hundred dollars for each day during which neglect continues, and, upon notice by the commissioner of insurance to that effect, its authority to do business in this state shall cease while such default continues.

Acts 1958, No. 125; Amended by Acts 1977, No. 691, §1; Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§567. Annual license

Societies which are now authorized to transact business in this state may continue such business until April first next following the effective date of this Part. The authority of such societies and all societies hereafter licensed, may thereafter be renewed annually, but in all cases to terminate on the succeeding April first. However, a license so issued shall continue in full force and effect until the new license is issued or specifically refused. For each such license or renewal the society shall pay the commissioner of insurance a fee of twenty-five dollars. A duly certified copy of such license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of this Part.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§568. Examination of societies; no adverse publications

A. The commissioner of insurance, or any person he may appoint, may examine any domestic, foreign, or alien society transacting or applying for admission to transact business in this state in the same manner as authorized for examination to domestic, foreign, or alien insurers. Requirements of notice and an opportunity to respond before findings are made public as provided in the laws regulating insurers shall also be applicable to the examination of societies.

B. The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued, upon statements furnished by the commissioner of insurance, provided that no examination shall be charged a domestic society and the examination fee for a foreign or alien society shall not exceed twenty-five dollars per day for each examiner.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§569. Foreign or alien society; admission

A. No foreign or alien society shall transact business in this state without a license issued by the commissioner of insurance. Any such society desiring admission to this state shall comply substantially with the requirements and limitations of this Part applicable to domestic societies. Any such society may be licensed to transact business in this state upon filing the following with the commissioner of insurance:

(1) A duly certified copy of its articles of incorporation.

(2) A copy of its bylaws, certified by its secretary or corresponding officer.

(3) A power of attorney to the secretary of state as prescribed in R.S. 22:575.

(4) A statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the commissioner of insurance, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province, or country, satisfactory to the commissioner of insurance of this state.

(5) Certification from the proper official of its home, state, territory, province, or country that the society is legally incorporated and licensed to transact business therein.

(6) Copies of its certificate forms.

(7) Such other information as the commissioner of insurance may deem necessary and upon a showing that its assets are invested in accordance with the provisions of this Part.

B. After approval by the commissioner of insurance and upon filing with the secretary of state of a duly certified copy of its articles of incorporation and bylaws, certified by its secretary or corresponding officer, and a power of attorney as hereinabove provided, the commissioner of insurance shall issue a license to such society to do business in this state until the following April first, and such license shall upon compliance with the provisions of this Section be renewed annually, but in all cases to terminate on the succeeding April first; however, the license shall continue in full force and effect until the new license is issued or specifically refused. Each foreign society shall pay the commissioner of insurance twenty-five dollars for each such license or renewal.

C. If the commissioner of insurance refuses to license any society, he shall reduce his ruling, order, or decision to writing and file the same in his office, and shall furnish a copy thereof, together with a statement of his reasons thereof, to the secretary, or other corresponding officer of the society.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§570. Injunction; liquidation; receivership of domestic society

A.(1) The commissioner of insurance shall notify a domestic society in writing of a deficiency and of the need to correct the deficiency when the society has done one of the following:

(a) Exceeded its powers.

(b) Failed to comply with any provision of this Part.

(c) Failed to fulfill its contracts in good faith.

(d) Failed to maintain its membership of four hundred or more after an existence of one year or more.

(e) Conducted business fraudulently or in a manner hazardous to its members, creditors, the public, or the business.

(2) After such notice the society shall have a thirty day period in which to comply with the commissioner's request for correction. If the society fails to comply, the commissioner shall notify the society of such findings of noncompliance and require the society to show cause why it should not be enjoined from carrying on any business until the violation complained of has been corrected, or why an action should not be commenced against the society under Part XVI of this Chapter.

B. If on such date the society does not present good and sufficient reasons why it should not be so enjoined or why such action should not be commenced, the commissioner of insurance may proceed in accordance with Part XVI of this Chapter for the rehabilitation or liquidation of such society.

C. No action under this Section shall be recognized in any court of this state unless brought upon request of the commissioner of insurance. Whenever a receiver is to be appointed for a domestic society, the court shall appoint the commissioner of insurance as the receiver.

D. The provisions of this Section relating to hearing by the commissioner of insurance and any action by the commissioner of insurance under Part XVI of this Chapter shall be applicable to a society which shall voluntarily determine to discontinue business.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§571. Suspension, revocation or refusal of license of foreign or alien society

A.(1) The commissioner of insurance shall notify in writing a foreign or alien society transacting or applying to transact business in this state of a deficiency and of the need to correct the deficiency when the society has done one of the following:

(a) Exceeded its powers.

(b) Failed to comply with any of the provisions of this Part.

(c) Failed to fulfill its contracts in good faith.

(d) Conducted its business fraudulently or in a manner hazardous to its members, creditors, or the public.

(2) After such notice the society shall have a thirty day period in which to comply with the commissioner's request for correction. If the society fails to comply, the commissioner shall notify the society of such findings of noncompliance and require the society to show cause why its license should not be suspended, revoked, or refused.

B. If on such date the society does not present good and sufficient reason why its authority to do business in this state should not be suspended, revoked, or refused, the commissioner may suspend or refuse the license of the society to do business in this state until satisfactory evidence is furnished to the commissioner that such suspension or refusal should be withdrawn or the commissioner may revoke the authority of the society to do business in this state.

C. Nothing contained in this Section shall be taken or construed as preventing any such society from continuing in good faith all contracts made in this state during the time such society was legally authorized to transact business herein.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§572. Injunction

No application or petition for injunction against any domestic, foreign, or alien society, or lodge thereof, shall be recognized in any court of this state unless made by the commissioner of insurance.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§573. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.

§574. Unfair methods of competition; unfair and deceptive acts and practices

Every society authorized to do business in this state shall be subject to the provisions of Part XXVI of this Chapter relating to unfair methods of competition and unfair or deceptive acts or practices; however, nothing in such provisions shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or as applying to or affecting the offering of benefits exclusively to members of persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§575. Service of process

A. Every society authorized to do business in this state shall appoint in writing the secretary of state to be its true and lawful attorney upon whom all lawful process in any action or proceeding against it shall be served, and shall agree in writing that any lawful process against it which is served on said attorney shall be of the same legal force and validity as if served upon the society, and that the authority shall continue in force so long as any liability remains outstanding in this state. Copies of such appointment, certified by the secretary of state, shall be deemed sufficient evidence thereof and shall be admitted in evidence with the same force and effect as the original thereof might be admitted.

B. Service shall only be made upon the secretary of state, or if absent, upon the person in charge of the secretary's office. It shall be made in duplicate and shall constitute sufficient service upon the society. When legal process against a society is served upon the secretary of state, he shall forthwith forward one of the duplicate copies by registered mail, postage prepaid, or by commercial courier as defined in R.S. 13:3204(D), when the party to be served is located outside of this state, directed to the secretary or corresponding officer of the society. No such service shall require a society to file its answer, pleading, or defense in less than thirty days from the date of mailing the copy of the service to the society. Legal process shall not be served upon a society except in the manner herein provided.

Acts 1987, No. 470, §1, eff. Jan. 1, 1988; Acts 1999, No. 395, §4.

§576. Review

All decisions and findings of the commissioner of insurance made under the provisions of this Part shall be subject to review in any court of competent jurisdiction of this state.

Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§577. Penalties

A. Any person who willfully makes a false or fraudulent statement in or relating to an application for membership in, or for the purpose of obtaining money or a benefit from, any society, shall be guilty of a misdemeanor, and upon conviction shall be fined not less than one hundred dollars nor more than five hundred dollars and imprisoned for not less than thirty days nor more than six months, or both.

B. Any person who willfully makes a false or fraudulent statement in any verified report or declaration under oath required or authorized by this Part or of any material fact or thing contained in a sworn statement concerning the death or disability of an insured for the purpose of procuring payment of a benefit named in the certificate, shall be guilty of perjury and shall be subject to the penalties therefor prescribed by law.

C. Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in this state shall be guilty of a misdemeanor, and upon conviction shall be fined not less than fifty dollars nor more than two hundred dollars.

D. Any person guilty of a willful violation of, or neglect or refusal to comply with, the provisions of this Part for which a penalty is not otherwise prescribed, shall upon conviction be subject to a fine not exceeding two hundred dollars.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

§578. Exemption of certain societies

A. Nothing contained in this Part shall be construed as to affect or apply to:

(1) Grand or subordinate lodges of societies, orders or associations now doing business in this state which provide benefits exclusively through local or subordinate lodges.

(2) Orders, societies, or associations which admit to membership only persons engaged in one or more crafts or hazardous occupations, in the same or similar lines of business, insuring only their own members and their families, and the ladies' societies or ladies' auxiliaries to such orders, societies, or associations.

(3) Domestic societies which limit their membership to employees of a particular city or town, designated firm, business house, or corporation which provide for a death benefit of not more than four hundred dollars or disability benefits of not more than three hundred fifty dollars to any person in any one year, or both.

(4) Domestic societies or associations of a purely religious, charitable, or benevolent description, which provide for a death benefit of not more than four hundred dollars or for disability benefits of not more than three hundred fifty dollars to any one person in any one year, or both.

B. Any such society or association described in Paragraphs (3) or (4) of Subsection A of this Section which provides for death or disability benefits for which benefit certificates are issued, and any such society or association included in Paragraph (4) of Subsection A of this Section which has more than one thousand members, shall not be exempted from the provisions of this Part, but shall comply with all requirements thereof.

C. No society which, by the provisions of this Section, is exempt from the requirements of this Part, except any society described in Paragraph (2) of Subsection A of this Section shall give or allow, or promise to give or allow to any person any compensation for procuring new members.

D. Every society which provides for benefits in case of death or disability resulting solely from accident, and which does not obligate itself to pay natural death or sick benefits, shall have all of the privileges and be subject to all the applicable provisions and regulations of this Part, except that the provisions thereof relating to medical examination, valuations of benefit certificates, and incontestability shall not apply to such society.

E. The commissioner of insurance may require from any society or association, by examination or otherwise, such information as will enable the commissioner to determine whether the society or association is exempt from the provisions of this Part.

F. Societies exempted under the provisions of this Section shall also be exempt from all other provisions of the insurance laws of this state.

Acts 1958, No. 125. Acts 1987, No. 470, §1, eff. Jan. 1, 1988.

PART XIV. THE INSURANCE CONTRACT

§611. Scope of Part

A. The applicable provisions of this Part shall apply to insurance other than ocean marine and foreign trade insurances. This Part shall not apply to life insurance policies not issued for delivery in this state nor delivered in this state. This Part also shall not apply to any health and accident insurance policy not issued for delivery in this state nor delivered in this state, except for any group policy covering residents of Louisiana, regardless of from where it was issued or delivered.

B. The exceptions in Subsection A of this Section do not apply to R.S. 22:627. The only exceptions from the requirements of R.S. 22:627 are those specifically stated therein.

Acts 1983, No. 188, §1; Acts 1989, No. 563, §1, eff. Sept. 1, 1989.

§612. Power to contract

A. Any person of competent legal capacity may contract for insurance.

B. A minor not less than fifteen years of age as at nearest birthday may, notwithstanding such minority, contract for life or health and accident insurance for his own benefit or for the benefit of his father, mother, spouse, child, brother, sister, or grandparent, or any person with an insurable interest and may exercise all rights and powers with respect to or under the contract as though of full legal age, and may surrender his interest therein and give a valid discharge for any benefit accruing or money payable thereunder. The minor shall not, by reason of his minority, be entitled to rescind, avoid, or repudiate the contract, or any exercise of a right or privilege thereunder; except, that such minor, not otherwise emancipated, shall not be bound by any unperformed agreement to pay, by promissory note or otherwise, any premium on any such insurance contract.

Acts 1958, No. 125.

§613. Insurable interest required; personal insurance; intentional acts exclusion

A. Any individual of competent legal capacity may procure or effect an insurance contract upon his own life or body for the benefit of any person. But no person shall procure or cause to be procured any insurance contract upon the life or body of another individual unless the benefits under such contract are payable to the individual insured or his personal representatives, or to a person having, at the time when such contract was made, an insurable interest in the individual insured.

B. If the beneficiary, assignee or other payee under any contract made in violation of this Section receives from the insurer any benefits thereunder accruing upon the death, disablement or injury of the individual insured, the individual insured or his executor or administrator, as the case may be, may maintain an action to recover such benefits from the person so receiving them.

C. "Insurable interest" as used in this Section and in R.S. 22:616 includes only interest as follows:

(1) In the case of individuals related closely by blood or by law, a substantial interest engendered by love and affection; and

(2) In the case of other persons, a lawful and substantial economic interest in having the life, health or bodily safety of the individual insured continue, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the individual insured.

(3) An individual, person, or entity heretofore or hereafter party to an agreement, contract, or option for the purchase or sale of a business or a firm or immovable property owned by a business or firm, or an interest therein or of shares of stock of a closed corporation or of an interest in such shares, has an insurable interest in the life of each individual party to such agreement, contract, or option, each individual shareholder of such closed corporation or each individual shareholder of a corporation, individual partner of a partnership, or individual member of a limited liability company owning such property, business, firm, or shares of stock for the purposes of such agreement, contract, or option, only, in addition to any insurable interest which may otherwise exist as to the life of such individual party or individual shareholder.

D.(1) No beneficiary, assignee, or other payee under any personal insurance contract shall receive from the insurer any benefits thereunder accruing upon the death, disablement, or injury of the individual insured when said beneficiary, assignee, or other payee is:

(a) Held by a final judgment of a court of competent jurisdiction to be criminally responsible for the death, disablement, or injury of the individual insured; or

(b) Judicially determined to have participated in the intentional, unjustified killing of the individual insured.

(2) Where such a disqualification exists, the policy proceeds shall be payable to the secondary or contingent beneficiary, unless similarly disqualified, or, if no secondary or contingent beneficiary exists, to the estate of the insured. Provided, that nothing contained herein shall prohibit payment pursuant to an assignment of the policy proceeds where such payment defrays the cost and expenses of the insured's funeral or expense incurred in connection with medical treatment of the insured. Provided, also, that nothing contained herein shall prohibit payment of insurance proceeds pursuant to a facility of payment clause, so long as such payment is not made to a beneficiary, assignee, or other payee disqualified by this Section.

(3) An executive pardon of any beneficiary, assignee, or other payee disqualified under this Subsection shall not affect the disqualification.

Acts 1958, No. 125; Amended by Acts 1979, No. 246, §1; Acts 1987, No. 743, §1; Acts 1995, No. 1244, §1.

§614. Insurable interest required; property insurances

A. No contract of insurance on property or of any interest therein or arising therefrom shall be enforceable except for the benefit of persons having an insurable interest in the things insured.

B. "Insurable interest" as used in this Section means any lawful and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction, or pecuniary damage.

Acts 1958, No. 125.

§614.1. Statutory life insurance beneficiaries

Notwithstanding any other law or regulation to the contrary, any religious, educational, eleemosynary, charitable, or benevolent institution or undertaking may be named beneficiary in or owner of any policy of life insurance issued by any life insurance company upon the life of any individual. The beneficiaries or owners aforenamed shall have an insurable interest for the full face of the policy and shall be entitled to collect same. On all policies of life insurance issued before August 21, 1992 by insurers in which any of the aforenamed shall have been designated beneficiaries in the policies, said beneficiaries shall have an insurable interest to the full extent of the face of the policy and be entitled to collect same, without penalty or deduction.

Acts 1991, No. 776, §1; Acts 1992, No. 1130, §1.

§615. Interest of the insured

When the name of a person intended to be insured is specified in the policy, such insurance can be applied only to his own proper interest. This Section shall not apply to life and health and accident insurances.

Acts 1958, No. 125.

§616. Application for insurance required

No life or health and accident insurance contract upon an individual, except a contract of group life insurance or of group or blanket health and accident insurance as defined in this Code, shall be made or effectuated unless at the time of the making of the contract the individual insured, being of competent legal capacity to contract, in writing applies therefor or consents thereto, except in the following cases:

(1) A spouse may effectuate such insurance upon the other spouse.

(2) Any person having an insurable interest in the life of a minor, or any person upon whom a minor is dependent for support and maintenance, may effectuate insurance upon the life of the minor.

Acts 1958, No. 125.

§616.1. Application for insurance; medical records

Every insurer who requires from an applicant for insurance a written authorization to obtain medical records of the applicant shall furnish copies of the medical records received by the insurer to the applicant upon written request.

Acts 1991, No. 732, §1.

§617. Alteration of application

A. Any application for insurance in writing by the applicant shall be altered solely by the applicant or by his written consent, except that insertions may be made by the insurer for administrative purposes only in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

B. Any insurer issuing an insurance contract upon such an application unlawfully altered by its officer, employee, or agent shall not have available in any action arising out of such contract, any defense which is based upon the fact of such alteration, or as to any item in the application which was so altered.

Acts 1958, No. 125.

§618. Application as evidence; life or health and accident insurance

A. No application for life or health and accident insurance shall be admissible in evidence in any action relative to the policy or contract, unless a correct copy of the application was attached to or otherwise made a part of the policy, or contract, when issued and delivered. This provision shall not apply to policies or contracts of industrial insurance subject to R.S. 22:213(A)(1)
and 259(2).

B. If any policy of life or health and accident insurance delivered in this state is reinstated or renewed, and the insured or the beneficiary or assignee of the policy makes written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall, within fifteen days after receipt of such request at its home office or at any of its branch offices, deliver or mail to the person making such request, a copy of such application. If such copy is not so delivered or mailed, the insurer shall be precluded from introducing the application as evidence in any action or proceeding based upon or involving the reinstatement or renewal of the policy.

Amended by Acts 1958, No. 98, §1; Acts 1958, No. 125; Acts 1989, No. 573, §1.

§619. Warranties and misrepresentations in negotiation; applications

A. Except as provided in Subsection B of this Section and R.S. 22:692, and R.S. 22:692.1, no oral or written misrepresentation or warranty made in the negotiation of an insurance contract, by the insured or in his behalf, shall be deemed material or defeat or void the contract or prevent it attaching, unless the misrepresentation or warranty is made with the intent to deceive.

B. In any application for life or health and accident insurance made in writing by the insured, all statements therein made by the insured shall, in the absence of fraud, be deemed representations and not warranties. The falsity of any such statement shall not bar the right to recovery under the contract unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Acts 1958, No. 125; Acts 1985, No. 506, §1.

§620. Approval of forms

A.(1) No basic insurance policy form, other than surety bond forms, or application form where written application is required and is to be attached to the policy, or be a part of the contract or printed life or health and accident rider or endorsement form shall be issued, delivered, or used unless it has been filed with and approved by the commissioner of insurance.

(2) For purposes of this Section, a basic insurance policy form shall include a certificate of coverage, any other evidence of coverage, or a subscriber agreement.

(3) This Section shall not apply to policies, riders, or endorsements designed to delineate the coverage for and used with relation to insurance upon a particular subject or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under such policy, and which is used at the request of the individual policyholder, contract holder, or certificate holder.

(4) Any insurer may insert in its policies any provisions or conditions required by its plan of insurance or method of operation which are not prohibited by the provisions of this Code.

B. Every such filing shall be made not less than forty-five days in advance of any such issuance, delivery, or use. At the expiration of forty-five days the form so filed shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the commissioner of insurance. The commissioner of insurance may extend by not more than an additional fifteen days the period within which he may so affirmatively approve or disapprove any such form, by giving notice of such extension before expiration of the initial thirty-day* period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such form shall be deemed approved. The commissioner of insurance may withdraw any such approval at any time for cause. Approval of any such form by the commissioner of insurance shall constitute a waiver of any unexpired portion of such initial fifteen-day waiting period.

C. The commissioner of insurance's order disapproving any such form or withdrawing a previous approval shall state the grounds therefor.

D. No such form shall knowingly be so issued or delivered as to which the commissioner of insurance's approval does not then exist.

E. The commissioner of insurance, may, by order, exempt from the requirements of this Section for so long as he deems proper, any insurance document or form or type thereof as specified in such order, to which in his opinion this Section may not practicably be applied, or the filing and approval of which are, in his opinion, not desirable or necessary for the protection of the public.

F. Insurers negotiating with and insuring special commercial entities shall be exempt from the form filing and approval requirements of this Section. The commissioner shall adopt rules and regulations necessary for the implementation of this Subsection including a provision defining special commercial entities which qualify for exemption. The definition of exempt commercial policyholder shall be reviewed periodically by the commissioner. This Subsection shall apply only to commercial property and casualty insurance. The regulations required by this Subsection shall be adopted no later than April 1, 2000.

Acts 1958, No. 125. Amended by Acts 1960, No. 176, §1; Acts 1993, No. 55, §1; Acts 1999, No. 124, §1, eff. June 9, 1999; Acts 1999, No. 479, §1.

*As appears in enrolled bill.

§621. Grounds for disapproval

The commissioner of insurance shall disapprove any such form of policy, application, rider, or endorsement, or withdraw any previous approval thereof, only:

(1) If it is in any respect in violation of or does not comply with law.

(2) If it does not comply with any controlling filing theretofore made and approved.

(3) If it contains or incorporates by reference any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract.

(4) If it has any title, heading, or other indication of its provisions which is misleading.

(5) If purchase of insurance thereunder is being solicited by deceptive advertising.

(6) If it is in any respect in violation of or does not fully comply with the law or any rule or regulation promulgated by the commissioner of insurance.

Acts 1958, No. 125; Acts 1991, No. 518, §1.

§622. Standard forms

The commissioner of insurance may from time to time, after hearing, promulgate such rules and regulations as he deems necessary to establish reasonable minimum standard conditions for basic benefits to be provided by health and accident insurance contracts which are subject to Part VI, for the purpose of expediting his approval of such contracts pursuant to this Code. No such promulgation shall be inconsistent with standard provisions as required pursuant to R.S. 22:623.

Acts 1958, No. 125.

§622.1. Standard automobile insurance form

The commissioner of insurance may promulgate such rules and regulations as necessary to establish reasonable standard provisions to be included in all policies of automobile insurance delivered or issued for delivery in this state. All such policies shall be written in language that can be easily understood by most automobile insurance consumers.

Acts 1993, No. 959, §1.

§622.2. Standard motor vehicle insurance form; prohibited provisions

No motor vehicle liability insurance policy nor any uninsured motorist coverage for bodily injury shall limit the coverage of, or the amount that can be recovered by, the named insured, or the spouse or other family member of the named insured, for whom the policy provides coverage, to any amount less than the highest policy limit provided in the policy for the respective coverage or potential recovery. Any recovery is limited to damages actually sustained. Any provision of a motor vehicle insurance policy issued in, or for delivery in, the state of Louisiana that is not in accord with this Section is contrary to the public policy of this state and shall be null, void, and unenforceable.

Added by Acts 2001, No. 1071, §1; Acts 2004, No. 395, §1; Acts 2005, No. 418, §1.

§623. Standard provisions

A. Insurance contracts shall contain such standard provisions as are required by the applicable chapters of this Code pertaining to contracts of particular kinds of insurance. The commissioner of insurance may waive the required use of a particular standard provision other than the provisions required in Part XV of this chapter in a particular insurance contract form if:

(1) He finds such provision unnecessary for the protection of the insured, and inconsistent with the purposes of the contract, and

(2) The contract is otherwise approved by him.

B. No insurance contract shall contain any provision inconsistent with or contradictory to any such standard provision used or required to be used, but the commissioner of insurance may approve any provision which is in his opinion more favorable to the insured than the standard provision or optional standard provision otherwise required. No endorsement, rider, or other documents attached to such contract shall vary, extend, or in any respect conflict with any such standard provision, so as to make the resulting effective provision less favorable to the insured than such standard provision.

C. In lieu of the standard provision required by this Code for contracts for particular kinds of insurance, except the standard fire policy as provided in Part XV, substantially similar standard provisions required by the law of a foreign or alien insurer's domicile may be used when approved by the commissioner of insurance.

Acts 1958, No. 125.

§624. Content of policies in general

A. The written instrument, in which a contract of insurance is set forth, is the policy.

B. A policy shall specify and conform to the following:

(1) The names of the parties to the contract. The insurer's name and if not a life insurer, the type of organization shall be clearly shown in the policy.

(2) The subject of the insurance.

(3) The risks insured against.

(4) The time at which the insurance thereunder takes effect and the period during which the insurance is to continue.

(5) A statement of the premium, other than as to surety bonds, and if other than life, accident or health, or title insurance, the premium rate.

(6) The conditions pertaining to the insurance.

(7) REPEALED BY ACTS 1990, No. 638, §1.

(8) Every printed portion of the text matter of the policy and of any endorsements or attached papers is printed in type the size of which shall be uniform and the face of which shall not be not less than ten-point type. The text matter shall include all printed matter except the name and address of the insurer, name or title of the policy, captions, sub-captions, and form numbers.

(9) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of each page.

C. If under the contract the exact amount of premiums is determinable only at termination or at periodic intervals of the contract, a statement of the basis and rates upon which the final premium is to be determined and paid shall be furnished any policy examining bureau having jurisdiction or to the insured upon request.

D. This section shall not apply to surety insurance contracts.

Acts 1958, No. 125; Acts 1989, No. 697, §1; Acts 1990, No. 638, §1; Acts 1999, No. 1312, §1, eff. July 12, 1999.

§625. Additional contents

A policy may contain additional provisions, which are not inconsistent with this Code, and which are,

(1) Required to be so inserted by the laws of the insurer's state of domicile; or

(2) Necessary, on account of the manner in which the insurer is constituted or operated, to state the rights and obligations of the parties to the contract.

Acts 1958, No. 125.

§626. Articles of incorporation; by-law provisions

No policy shall contain any provision purporting to make any portion of the articles of incorporation, by-laws, or other constituent document of the insurer a part of the contract unless such portion is set forth in full in the policy. Any policy provision in violation of this Section shall be invalid.

Acts 1958, No. 125.

§627. Quoted premium shall include all charges; dollar amount required

A. The premium quoted by the insurer shall be a specific dollar amount which shall be inclusive of all fees, charges, premiums, or other consideration charged for the insurance or for the procurement thereof, except that:

(1) In any subsequent modification of the policy, the insurer may require that evidence of insurability be furnished at the insured's expense;

(2) The premium and premium tax on a surplus lines policy shall be separately stated on the declaration page.

B.(1) No insurer or its officer, employee, agent, broker, solicitor, or other representative shall charge or receive any fee, compensation, or consideration for insurance which is not included in the premium quoted to the insured and the premium specified in the policy delivered to the insured, except for the premium tax on a surplus lines policy which shall be separately stated, and except for reimbursement for expenses due the agent, and except for an agency fee, if any, as authorized hereunder.

(2)(a) The agent may receive reimbursement from the insured for expenses incurred by the agent directly related to the insurance coverage for the insured. In addition, the agent may charge a reasonable agency fee related to the services provided by the agent. Any reimbursement or agency fee shall be itemized separately on an invoice statement. A single invoice may be used to make known all charges. Each such charge must be prominently disclosed and itemized separately on the invoice.

(b) The reimbursement for expense and agency fees shall not be considered premium for any purpose, nor shall they be subject to premium taxes or surplus lines premium taxes. Agency fees for criminal bail bond or homeowners or personal automobile insurance that are standard risks insurable at standard rates shall not exceed twenty-five dollars.

(c) The commissioner of insurance may promulgate rules to enforce the provisions of this Section.

C. Each policy delivered to the insured shall have the full and accurate dollar amount of the premium disclosed on the policy, which shall be inclusive of all fees, charges, premiums, or other consideration charged for the insurance or for the procurement thereof, except that, in any subsequent modification of the policy, the insurer may require that evidence of insurability be furnished at the insured's expense, and except that the premium tax on a surplus lines policy shall be separately stated, and except for reimbursement of expenses and agency fees as authorized in Paragraph B(2).

D.(1) Any person who aids, assists in, or procures the preparation of any invoice, insurance policy or part thereof, or any other document used in the charging of any fee, compensation, or other consideration, except as provided in Subsections B and C of this Section, which is not included in the premium quoted by the insurer and in the premium disclosed on the policy shall be liable to the insured.

(2) In this Subsection, a person who procures the preparation of any document specified in Paragraph (1) includes a person who knowingly permits the preparation of such a document to be done or participated in by a subordinate or employee, whether or not that person directly ordered or caused the subordinate or employee to prepare the document. It shall not include a person furnishing typing, reproducing, or providing other clerical or mechanical assistance with respect to a document.

E.(1) The commissioner may convene a hearing, pursuant to the provisions of Part XXIX of the Insurance Code, R.S. 22:1351 et seq., and upon making a written finding that an amount in excess of the quoted premium has been received, shall issue a written order to the person who received the excess amount to refund it to the person who paid it. Such amount shall be paid within thirty days after the date of the commissioner's order in the matter.

(2) Upon such determination, the person ordered to pay the refund may appeal to the Nineteenth Judicial District Court after paying to the commissioner a sum equal to one-half of the assessed refund. The commissioner shall keep any such sum paid in escrow and shall return it promptly to the payor if he prevails in the court proceeding. Thirty days after the commissioner's written findings or thirty days after final denial of the appeal, any order of the commissioner made pursuant to this Section shall be enforceable as a judgment under the Code of Civil Procedure.

F. Each violation of Subsection B or C of this Section shall be theft and a violation of R.S. 14:67.

G. The commissioner may assess one or more of the following penalties against any person who violates the provisions of this Section:

(1) A fine in an amount not greater than five thousand dollars,

(2) A suspension of an insurer's certificate of authority or an agent's, broker's, or solicitor's license, or

(3) A revocation of an insurer's certificate of authority or an agent's, broker's, or solicitor's license.

H. The provisions of this Section shall apply to all policies except life, accident, health, and reinsurance policies.

Acts 1988, No. 172, §1, eff. June 29, 1988; Acts 1989, No. 563, §1, eff. Sept. 1, 1989; Acts 1992, No. 1130, §2; Acts 1995, No. 704, §1; Acts 1999, Nos. 135, 551, §§1; Acts 2004, No. 466, §1, eff. January 1, 2005.

§628. Must contain entire contract with exceptions

No agreement in conflict with, modifying, or extending the coverage of any contract of insurance shall be valid unless it is in writing and physically made a part of the policy or other written evidence of insurance, or it is incorporated in the policy or other written evidence of insurance by specific reference to another policy or written evidence of insurance. This Section shall not apply to contracts as provided in Part XV of this Chapter.

The provisions of this Section shall apply where a policy or other written evidence of insurance is coupled by specific reference with another policy or written evidence of insurance in existence as of the effective date hereof or issued thereafter.

Any written agreement in conflict with, modifying, or extending the coverage of any contract of insurance shall be deemed to be physically made a part of a policy or other written evidence of insurance, within the meaning of this section, whenever such written agreement makes reference to such policy or evidence of insurance and is sent to the holder of such policy or evidence of insurance by United States mail, postage prepaid, at such holder's last known address as shown on such policy or evidence of insurance or is personally delivered to such holder.

Acts 1958, No. 125. Amended by Acts 1976, No. 150, §1; eff. July 20, 1976; Acts 1977, No. 312, §1, eff. July 10, 1977; Acts 1979, No. 368, §1, eff. July 10, 1979.

§629. Limiting actions; jurisdiction

A. No insurance contract delivered or issued for delivery in this state and covering subjects located, resident, or to be performed in this state or any group health and accident policy insuring a resident of this state, regardless of where made or delivered shall contain any condition, stipulation, or agreement:

(1) Requiring it to be construed according to the laws of any other state or country except as necessary to meet the requirements of the motor vehicle financial responsibility laws of such other state or country;

(2) Depriving the courts of this state of the jurisdiction of action against the insurer; or

(3) Limiting right of action against the insurer to a period of less than twelve months next after the inception of the loss when the claim arises under any insurance classified and defined in R.S. 22:6(10), (11), (12), and (13), or to a period of less than one year from the time when the cause of action accrues in connection with all other insurances unless otherwise specifically provided in this Code.

B. Any such condition, stipulation, or agreement in violation of this Section shall be void, but such voiding shall not affect the validity of the other provisions of the contract.

Acts 1958, No. 125; Acts 1983, No. 188, §1; Acts 1987, No. 210, §1, eff. July 2, 1987.

§630. Execution of policies

A. Every insurance contract shall be executed in the name of and on behalf of the insurer by its officer, employee, or representative duly authorized by the insurer.

B. A facsimile signature of any such executing officer, employee, or representative may be used in lieu of an original signature.

C. REPEALED BY ACTS 1999, No. 882, §2, eff. July 2, 1999.

Acts 1958, No. 125; Acts 1999, No. 882, §2, eff. July 2, 1999.

§631. Duration of binders

A "binder" is used to bind insurance temporarily pending the issuance of the policy. No binder shall be valid beyond the issuance of the policy as to which it was given.

Acts 1958, No. 125. Amended by Acts 1979, No. 173, §1.

§632. Liability of agents on binder

The commissioner of insurance may suspend or revoke the license of any agent issuing or purporting to issue any binder as to any insurer named therein as to which he is not then authorized so to bind.

Acts 1958, No. 125.

§633. Underwriters' and combination policies

A. Two or more authorized insurers may jointly issue, and shall be jointly and severally liable on, an underwriters' policy bearing their names. Any one insurer may issue policies in the name of an underwriter's department and such policies shall plainly show the true name of the insurer.

B. Two or more authorized insurers may, with the commissioner of insurance's approval, issue a combination policy which shall contain provisions substantially as follows:

(1) That the insurers executing the policy shall be severally liable for the full amount of any loss or damage, according to the terms of the policy, or for specified percentages or amounts thereof, aggregating the full amount of insurance under the policy.

(2) That service of process, or of any notice or proof of loss required by such policy, upon any of the insurers executing the policy, shall constitute service upon all such insurers.

C. This Section shall not apply to co-surety obligations.

Acts 1958, No. 125.

§634. Delivery of policy

A. Subject to the insurer's requirements as to payment of premium, every policy shall be delivered to the insured or to the person entitled thereto within a reasonable period of time after its issuance.

B. In event the original policy is delivered or is so required to be delivered to or for deposit with any vendor, mortgagee, or pledgee of any motor vehicle or aircraft, and in which policy any interest of the vendee, mortgagor, or pledgor in or with reference to such vehicle or aircraft is insured, a duplicate of such policy, or memorandum thereof setting forth the type of coverage, limits of liability, premiums for the respective coverages, and duration of the policy, shall be delivered by the vendor, mortgagee, or pledgee to each such vendee, mortgagor, or pledgor named in the policy or coming within the group of persons designated in the policy to be so included.

Acts 1958, No. 125.

§635. Renewal of policy; increase in premiums prohibited

A. Any insurance policy terminating by its terms at a specified expiration date and not otherwise renewable may be renewed or extended at the option of the insurer and upon a currently authorized renewal form and at the premium rate then required therefor for a specific additional period or periods by a certificate or by endorsement of the policy, and without requiring the issuance of a new policy.

B. No insurer shall increase the premium charged for an automobile liability insurance policy at the time of renewal for any insured solely on the grounds that the insured's policy has lapsed provided the policy is renewed within ten days after the date of termination.

Acts 1958, No. 125; Acts 1997, No. 702, §1.

§635.1. Automobile insurance policies; refusal to issue or renew; age discrimination

No insurer shall refuse to issue or renew an automobile insurance policy to any person over the age of sixty-five based upon the age of the insured provided the insured is mentally and physically capable of driving an automobile and possesses a valid Louisiana operator's license issued by the office of motor vehicles in the Louisiana Department of Public Safety and Corrections.

Acts 1992, No. 331, §1.

§635.2. Automobile insurance policies; increase in premium; age discrimination

No insurer shall increase the premium charged for an automobile liability insurance policy for any insured solely on the grounds that the insured has attained the age of sixty-five or older.

Acts 1993, No. 205, §1.

§635.3. Homeowner's insurance; insurer's nonrenewal without cause; inclusion in insured's file prohibited

A. Whenever a policy of homeowner's insurance is not renewed by the insurer and such nonrenewal is without cause, the fact of such nonrenewal shall not be retained in the insured's file with that insurer. Such nonrenewal shall not be considered a cancellation or nonrenewal for cause. The insurer shall not utilize such nonrenewal as a reason for an increase in the insured's rate for equivalent coverage to that which was not renewed.

B. In this Section, nonrenewal "without cause" shall not include nonrenewal by the insurer for any of the following reasons:

(1) Nonrenewal at the request of the insured;

(2) Failure of the insured to pay the agreed premium;

(3) Fraud on the part of the insured; or

(4) Material misrepresentation of a material fact in application for a new policy or for renewal of an existing policy.

C. No insurer providing property, casualty, or liability insurance shall cancel or fail to renew a homeowner's policy of insurance or to increase the policy deductible that has been in effect and renewed for more than three years unless based on nonpayment of premium, fraud of the insured, a material change in the risk being insured, two or more claims within a period of three years, or if continuation of such policy endangers the solvency of the insurer. This Subsection shall not apply to an insurer that ceases writing homeowner's insurance or to policy deductibles increased for all homeowners policies in the state.

Acts 1988, No. 460, §1; Acts 1992, No. 594, §1; Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996; Acts 2003, No. 456, §3.

§635.4. Homeowners insurance policies; conversion of policy forms

A. With the approval of the commissioner of insurance an insurer may convert an entire class of homeowner policies to another homeowner policy form, which has been submitted to and approved by the commissioner, as those homeowners policies are renewed. The terms and conditions of such policies, subject to the conversion, shall be continued in full force and effect for the term of the policy. The conversion provided for in this Section shall not constitute the cancellation or nonrenewal of any policy and shall not be grounds for the cancellation or nonrenewal of any policy by the insurer.

B. A conversion by an insurer shall be deemed approved by the commissioner unless disapproved within forty-five days of the filing of the proposed conversion with the commissioner.

C. All homeowner insurance policies, which have been properly filed and converted pursuant to this Section and the conversion of which will result in a rate change, shall be subject to the laws governing rate changes under Subpart A of Part XXX of this Chapter, R.S. 22:1401 et seq.

Added by Acts 2004, No. 358, §1; Acts 2005, No. 258, §1.

§636. Cancellation by insurer

A. Cancellation by the insurer of any policy which by its terms is cancelable at the option of the insurer, or of any binder based on such policy, may be effected as to any interest only upon compliance with either or both of the following:

(1)(a) Written notice of such cancellation must be actually delivered or mailed to the insured or to his representative in charge of the subject of the insurance not less than thirty days prior to the effective date of the cancellation except when termination of coverage is for nonpayment of premium.

(b) Upon the written request of the named insured, the insurer shall provide to the insured in writing the reasons for cancellation of the policy. There shall be no liability on the part of and no cause of action of any nature shall arise against any insurer or its agents, employees, or representatives for any action taken by them to provide the reasons for cancellation as required by this Subparagraph.

(2) Like notice must also be so delivered or mailed to each mortgagee, pledgee, or other known person shown by the policy to have an interest in any loss which may occur thereunder. For purposes of this Paragraph "delivered" includes electronic transmittal, facsimile, or personal delivery.

(3) Where written notice of cancellation or nonrenewal is required and the insurer elects to mail the notice, the running of the time period between the date of mailing and the effective date of termination of coverage shall commence upon the date of mailing.

(4) Any policy may be cancelled by the company at any time during the policy period for failure to pay any premium when due whether such premium is payable directly to the company or its agent or indirectly under a premium finance plan or extension of credit, by mailing or delivering to the insured written notice stating when, not less than ten days thereafter, such cancellation shall be effective. Nothing in this Code shall mandate a separate notice of lapse for nonpayment of premium of a policy defined as provided by R.S. 22:1405(G).

B. The mailing of any such notice shall be effected by depositing it in a sealed envelope, directed to the addressee at his last address as known to the insurer or as shown by the insurer's records, with proper prepaid postage affixed, in a letter depository of the United States Post Office. The insurer shall retain in its records any such item so mailed, together with its envelope, which was returned by the Post Office upon failure to find, or deliver the mailing to the addressee.

C. The affidavit of the individual making or supervising such a mailing, shall constitute prima facie evidence of such facts of the mailing as are therein affirmed.

D.(1) The portion of any premium paid to the insurer on account of the policy, including unearned commission, unearned because of the cancellation and in amount as computed on the pro rata basis, must be actually paid to the insured, the agent of the insured, or other person entitled thereto as shown by the policy or by any endorsement thereon, or be mailed to the insured or such person as soon as practicable following such cancellation. Any such payment may be made by cash, or by check, bank draft, or money order.

(2) When payment is sent to the agent of the insured, the insurer shall be required to provide notice to the insured, at the time of cancellation, that a return of unearned premium may be generated by the cancellation.

E. This Section shall not apply to temporary life insurance binders nor to contracts of life or health and accident insurance which do not contain a provision for cancellation prior to the date to which premiums have been paid, nor to the contracts provided in Part XV of this Chapter.

F. No insurer shall cancel or refuse to renew any policy of group or family group health and accident insurance except for nonpayment of premium or failure to meet the requirements for being a group or family group insurance policy until sixty days after the insurer has mailed written notice of such cancellation or nonrenewal by certified mail to the policyholder. The notice shall also include the reason the policy is being cancelled.

G. No insurer shall fail to renew a policy providing property or casualty insurance unless a notice of intention to not renew is mailed or delivered to the named insured at the address shown on the policy at least thirty days prior to the effective date of nonrenewal. This Subsection shall not apply:

(1) To policies regulated by R.S. 22:636.1 and 636.4.

(2) If the insurer has manifested its willingness to renew the policy either through the same company or a company in the same group of companies.

(3) In the case of nonpayment of the premium.

(4) If the named insured has provided written notification to the insurer of the insured's intention to not renew the policy.

(5) In cases of fraud by the insured.

H. Notice of cancellation or nonrenewal given by the insurer in accordance with this Chapter shall be deemed sufficient. The insurance producer, insurance agent, or insurance broker shall not be required to give any separate or additional notice of cancellation or n onrenewal.

Acts 1958, No. 125; Acts 1985, No. 938, §1, eff. Jan. 1, 1986; Acts 1987, No. 510, §1; Acts 1990, No. 877, §1; Acts 1991, No. 741, §1; Acts 2001 No. 1052; §1; Acts 2004, No. 44, §1; Acts 2004, No. 549, §1.

§636.1. Automobile, property, casualty, and liability insurance policies, cancellations

A. As used in this Chapter:

(1) "Policy" means an automobile liability, automobile physical damage, or automobile collision policy, or any combination thereof, delivered or issued for delivery in this state, or any binder based on such a policy, insuring a single individual or husband and wife resident of the same household, as named insured, and under which the insured vehicles therein designated are of the following types only:

(a) A motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance for passengers, nor rented to others; or

(b) Any other four-wheel motor vehicle with a load capacity of fifteen hundred pounds or less which is not used in the occupation, profession or business of the insured; provided, however, that this shall not apply (1) to any policy issued under an automobile assigned risk plan, or (2) to any policy insuring more than four automobiles, or (3) to any policy covering garage, automobile sales agency, repair shop, service station or public parking place operation hazards.

(2) "Automobile liability coverage" includes only coverages of bodily injury and property damage liability, medical payments and uninsured motorists coverage.

(3) "Automobile physical damage coverage" includes all coverage of loss or damage to an automobile insured under the policy except loss or damage resulting from collision or upset.

(4) "Automobile collision coverage" includes all coverage of loss or damage to an automobile insured under the policy resulting from collision or upset.

(5) "Renewal" or "to renew" means the issuance and delivery by an insurer of a policy replacing at the end of the policy period a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term. However, no policy of insurance for a period of less than six months shall be issued by an insurer to any person who has been issued two or more citations for violations of R.S. 32:851 et seq. or R.S. 32:861 et seq., and any policy issued to a person receiving two or more citations shall be considered as if written for a policy period or term of six months. Any policy which is written for a term longer than one year or any policy which is renewed by an insurer shall be for the same term as the original or expired policy, or any policy with no fixed expiration date shall for the purpose of this Chapter be considered as if written for successive policy periods or terms of one year. Such a policy may be terminated at the expiration of any annual period upon giving twenty days notice of cancellation prior to such anniversary date. This cancellation shall not be subject to any other provisions of this Chapter.

(6) "Nonpayment of premium" means failure of the named insured to discharge when due any of his obligations in connection with the payment of premiums on a policy, or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit.

B.(1) A notice of cancellation of a policy shall be effective only if it is based on one or more of the following reasons:

(a) Nonpayment of premium.

(b) The driver's license or motor vehicle registration of the named insured or of any other operator who either resides in the same household or customarily operates an automobile insured under the policy has been under suspension or revocation during the policy period, or, if the policy is a renewal, during its policy period or the one hundred eighty days immediately preceding its effective date.

(c) Fraud or material misrepresentation in the presentation of a claim.

(d) Nonreceipt by the insurer of an application for insurance in which a valid binder has been issued.

(2) This Subsection shall not apply to nonrenewal or to any policy or coverage which has been in effect less than sixty days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal policy. After an insurer has paid and satisfied an insured's third physical damage claim, the modification of such insured's automobile physical damage coverage by the inclusion of a deductible not exceeding fifty dollars shall not be deemed a cancellation of the coverage or of the policy.

C. No insurer shall cancel or fail to renew a policy purely because of age. Some legitimate reason, such as physical or mental infirmity, must be specified before an insurer may cancel or refuse to renew a policy.

D.(1) No notice of cancellation of a policy to which Subsection B or C of this Section applies shall be effective unless mailed by certified mail or delivered by the insurer to the named insured at least thirty days prior to the effective date of cancellation; however, when cancellation is for nonpayment of premium at least ten days notice of cancellation accompanied by the reason therefor shall be given. In the event of nonpayment of premiums for a binder, a ten day notice of cancellation shall be required before the cancellation shall be effective. Notice of cancellation for nonpayment of premiums shall not be required to be sent by certified mail. Unless the reason accompanies the notice of cancellation, the notice of cancellation shall state or be accompanied by a statement that upon written request of the named insured, mailed or delivered to the insurer within six months after the effective date of cancellation, the insurer will specify the reason for such cancellation. This Subsection shall not apply to nonrenewal.

(2) There shall be no liability on the part of and no cause of action of any nature shall arise against any insurer or its agents, employees, or representatives for any action taken by them to provide the reasons for cancellation as required by this Subsection.

(3)(a)(i) Payment of an initial, renewal, or installment insurance premium by the insured to an insurer or an insurance agent with a check or other negotiable instrument which is returned to the payee by the institution upon which it is drawn for insufficient funds available in the account, for lack of credit, for the reason the account is closed, for stopped payment, or for any other reason shall be deemed grounds for the insurer to cancel the binder or policy from the date the premium payment was due for the initial or renewal term, whichever is applicable.

(ii) The provisions of this Paragraph shall apply to automobile liability policies and to property, casualty, and liability policies.

(b)(i) The insurance agent shall immediately, and in no case later than ten days after the agent or premium finance company has received notice of the returned check or negotiable instrument, notify the insurer of the receipt of the returned check or negotiable instrument.

(ii) The insurer shall immediately, and in no case later than ten days after the agent or premium finance company has notified the insurer, notify the named insured, by certified mail or delivering to the named insured a written notice that the policy is canceled from the date the premium payment was due. The insurer shall advise the named insured that the policy shall be reinstated effective from the date the premium payment was due for the term of the policy only if the named insured or his legal representative presents to the insurer a cashier's check or money order for the full amount of the returned check or other negotiable instrument within ten days of the date that the notice of cancellation was mailed.

(c) Upon expiration of the ten-day period, either:

(i) The insurer shall reinstate the insured's policy, from the date that the premium was due, and shall pay directly to the insurance agent all funds paid to the insurer by the insured or his legal representative to replace the dishonored check or other negotiable instrument; or

(ii) Cancellation of the policy shall remain effective, when the insured or his legal representative has failed to redeem the dishonored check or other negotiable instrument before expiration of the ten-day period.

(d)(i) Within ten days of the expiration of the ten-day notice, the insurer shall return all funds paid by the insurance agent to the insurer on behalf of the insured except when an insurance premium finance company has funded an insured's policy, the insurer shall return those funds directly to the insurance premium finance company. These funds shall be returned by check or other negotiable instrument and shall not be placed on the agent's or premium finance company's account currents unless the agent or premium finance company and the insurer have agreed to other methods for handling these funds. Funds received by the insurance premium finance company in excess of the amount funded by the insurance premium finance company shall be forwarded to the insurance agent.

(ii) The original or a copy of the returned dishonored check or negotiable instrument, front and back, mailed or faxed, to the insurance company shall be proof of the returned dishonored check or negotiable instrument by the financial institution and shall be considered sufficient evidence in any future litigation.

(iii) When an insured pays the dishonored check by delivery to the agent of cash or a certified check, the agent shall notify the insurer within ten days of the payment of the dishonored check.

(e) In the event the policy has been canceled back to the date of inception or premium payment due in accordance with this Paragraph, the sixty-day periods referred to in R.S. 9:3550(H) and R.S. 22:636(F) shall not apply. The funds shall be returned by the insurer by check within ten days of the expiration of the ten-day notice of cancellation.

(4) (a) In the event that an agent, broker, surplus lines insurance broker, or insurance solicitor incorrectly states the premium amount for the automobile liability policy, the insured may cancel the policy and shall be returned the initial payment of premium, including fees and costs, less the prorated cost for the period of time of coverage at the initial stated premium, including fees and costs, and may cancel the insurance coverage, without penalty or loss of coverage, for the period of time that the premium, including fees and costs, was paid.

(b) When an insurance premium finance company has funded an insured's policy and the policy is cancelled, the insurer shall return the funds directly to the insurance premium finance company. Any funds received by the insurance premium finance company in excess of the amount owed to the insurance premium finance company by the insured shall be forwarded to the insurance agent to be returned to the insured. The insurer shall not withhold any more funds from the insurance premium finance company than would otherwise be withheld from the insured. No insurer shall assess a service charge for this transaction.

E.(1) No insurer shall fail to renew a policy unless it shall mail or deliver to the named insured, at the address shown in the policy, at least twenty days advance notice of its intention not to renew. This Subsection shall not apply:

(a) If the insurer has manifested its willingness to renew.

(b) In case of nonpayment of premium; provided that, notwithstanding the failure of an insurer to comply with this Subsection, the policy shall terminate on the effective date of any other insurance policy with respect to any automobile designated in both policies.

(c) If the insurer or a company within the same group as the insurer has offered to issue a renewal policy to the named insured.

(d) If the named insured has provided written notification to the insurer of the insured's intention not to renew the policy.

(2) Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal.

(3) Upon the written request of the named insured, the insurer shall provide to the insured in writing the reasons for nonrenewal of the policy. There shall be no liability on the part of and no cause of action of any nature shall arise against any insurer or its agents, employees, or representatives for any action taken by them to provide the reasons for nonrenewal as required by this Paragraph.

F. Proof of mailing of notice of cancellation, or of intention not to renew or of reasons for cancellation, to the named insured at the address shown in the policy, shall be sufficient proof of notice.

G. When a policy of automobile liability insurance is cancelled, other than for nonpayment of premium, or in the event of failure to renew a policy of automobile liability insurance to which Subsection D applies, the insurer shall notify the named insured of his possible eligibility for automobile liability insurance through the automobile liability assigned risk plan. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew.

H. REPEALED BY ACTS 1987, No. 510, §2.

I. There shall be no liability on the part of and no cause of action of any nature shall arise against the commissioner of insurance or against any insurer, its authorized representative, its agents, its employees, or any firm, person or corporation furnishing to the insurer information as to reasons for cancellation, for any statement made by any of them in any written notice of cancellation, or in any other communication, oral or written specifying the reasons for cancellation, or the providing of information pertaining thereto, or for statements made or evidence submitted at any hearings conducted in connection therewith.

J. Where written notice of cancellation or nonrenewal is required and the insurer elects to mail the notice, the running of the time period between the date of mailing and the effective date of termination of coverage shall commence upon the date of mailing.

K. No insurer shall cancel an automobile insurance policy written or issued for delivery in this state belonging to an insured over the age of sixty-five based upon the age of the insured provided the insured is mentally and physically capable of driving an automobile and possesses a valid Louisiana operator's license issued by the office of motor vehicles in the Louisiana Department of Public Safety and Corrections.

L. No insurer shall cancel an automobile insurance policy for any insured solely on the ground that the insured has submitted a single claim under his or her policy for damage incurred or arising from the operation of an automobile. The provisions of this Subsection shall not prohibit an insurer from increasing the cost of the insured's premium based on the number of claims submitted under his or her policy for damage incurred or arising from the operation of an automobile. For the purposes of this Subsection, an incident shall be deemed a claim only when there is a demand for payment under the terms of the policy. A report of loss or a question relating to coverage shall not independently establish a claim.

Added by Acts 1968, No. 632, §1. Amended by Acts 1974, No. 452, §1; Acts 1985, No. 938, §2, eff. Jan. 1, 1986; Acts 1986, No. 830, §1; Acts 1987, No. 510, §§1, 2; Acts 1988, No. 356, §1, eff. July 7, 1988; Acts 1991, No. 981, §1; Acts 1992, No. 331, §1; Acts 1993, No. 56, §1; Acts 1993, No. 215, §1; Acts 1993, No. 1020, §1; Acts 1995, No. 518, §1; Acts 1995, No. 875, §1; Acts 1997, No. 358, §1; Acts 1999, Nos. 1008, 1073, §§1; Acts 2003, No. 298, §1; Acts 2004, No. 826, §1.

§636.2. Property, casualty, and liability insurance policies; cancellation and nonrenewal provisions; nonrenewal for rate inadequacy; certain prohibitions

A.(1) Any insurer cancelling or refusing to renew a policy providing property, casualty, or liability insurance on any property shall, upon written request of the named insured therein, mailed or delivered to the insurer within six months after the effective date of cancellation or expiration, specify in writing the reason or reasons for such cancellation or refusal to renew.

(2) There shall be no liability on the part of and no cause of action of any nature shall arise against any insurer or its agents, employees, or representatives for any action taken by them to provide the reasons for cancellation as required by this Subsection.

(3) Any nonrenewal for which the reason, in whole or in part, is inadequacy or insufficiency of the rate or premium for coverage shall be permitted only after the insurer has sought actuarily justified rate relief from the Louisiana Insurance Rating Commission and such rate relief has been rejected by the commission.

B. There shall be no liability on the part of and no cause of action of any nature shall arise against the commissioner of insurance or against any insurer, its authorized representative, its agents, its employees, or any firm, person or corporation furnishing to the insurer information as to reasons for cancellation or refusal to renew, or in any other communication, oral or written, specifying the reasons for cancellation or refusal to renew, or the providing of information pertaining thereto, or for statements made or evidence submitted at any hearings conducted in connection therewith.

C. No insurer providing property, casualty, or liability insurance shall cancel or refuse to issue or fail to renew a homeowner's policy solely on the basis that the insured owns or possesses an all-terrain vehicle (ATV). The provisions of this Subsection shall not prohibit an insurer providing property, casualty, or liability insurance from specifically excluding coverage for damage incurred or arising from the operation of an all-terrain vehicle.

D. No insurer providing property, casualty, or liability insurance shall cancel or fail to renew a homeowner's policy of insurance or to increase the policy deductible that has been in effect and renewed for more than three years unless based on nonpayment of premium, fraud of the insured, a material change in the risk being insured, two or more claims within a period of three years, or if continuation of such policy endangers the solvency of the insurer. This Subsection shall not apply to an insurer that ceases writing homeowner's insurance or to policy deductibles increased for all homeowners' policies in the state. For the purposes of this Subsection, an incident shall be deemed a claim only when there is a demand for payment by the insured or the insured's representative under the terms of the policy. A report of a loss or a question relating to coverage shall not independently establish a claim.

Added by Acts 1968, No. 51, §1; Acts 1987, No. 510, §1; Acts 1988, No. 953, §1, eff. Sept. 1, 1988; Acts 1991, No. 840, §1; Acts 1992, No. 594, §1; Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996; Acts 2004, No. 826, §1.

§636.3. Cancellation by insurer; failure to maintain membership in required organization

A. An insurer may cancel any policy of insurance for failure to maintain membership in an organization if membership is a condition precedent to insurance coverage.

B. Cancellation under this Section by the insurer of any policy or of any binder based on such policy, may be effected as to any interest only upon compliance with either or both of the following:

(1)(a) Written notice of such cancellation must be actually delivered or mailed to the insured or to his representative in charge of the subject of the insurance not less than twenty days prior to the effective day of the cancellation.

(b) Upon the written request of the named insured, the insurer shall provide to the insured in writing the reasons for cancellation of the policy. There shall be no liability on the part of and no cause of action of any nature shall arise against any insurer or its agents, employees, or representatives for any action taken by them to provide the reasons for cancellation as required by this Subparagraph.

(2) Like notice must also be so delivered or mailed to each mortgagee, pledgee, or other known person shown by the policy to have an interest in any loss which may occur thereunder.

(3) Where written notice of cancellation or nonrenewal is required and the insurer elects to mail the notice, the running of the time period between the date of mailing and the effective date of termination of coverage shall commence upon the date of mailing.

C. The mailing of any such notice shall be effected by depositing it in a sealed envelope, directed to the addressee at his last address as known to the insurer or as shown by the insurer's records, with proper prepaid postage affixed, in a letter depository of the United States post office. The insurer shall retain in its records any such item so mailed, together with its envelope, which was returned by the post office upon failure to find, or deliver the mailing to the addressee.

D. The affidavit of the individual making or supervising such a mailing, shall constitute prima facie evidence of such facts of the mailing as are therein affirmed.

E. The portion of any premium paid to the insurer on account of the policy, unearned because of the cancellation and in an amount as computed on the pro rata basis, must be actually paid to the insured, or other person entitled thereto as shown by the policy or by any endorsements thereon, or be mailed to the insured, his representative, or such other person as soon as practicable following such cancellation. Any such payment may be made by cash, or by check, bank draft, or money order.

Added by Acts 1976, No. 203, §1. Amended by Acts 1985, No. 938, §1, eff. Jan. 1, 1986; Acts 1987, No. 510, §1; Acts 1988, No. 353, §1.

§636.4. Commercial insurance; cancellation and renewal

A. This Section shall apply to commercial property insurance policies and commercial multi-peril insurance policies; workers' compensation insurance, professional errors and omissions policies, commercial liability insurance policies, other than aviation and employers' liability insurance policies. It shall not apply to reinsurance, excess and surplus lines insurance, residual market risks, multistate location risks, policies subject to retrospective rating plans, excess or umbrella policies, and such other policies that are exempted by the commissioner of insurance.

B. For the purposes of this Section, the following terms shall mean:

(1) "Cancellation" means termination of a policy at a date other than its expiration date.

(2) "Expiration date" means the date upon which coverage under a policy ends. It also means, for a policy written for a term longer than one year or with no fixed expiration date, each annual anniversary date of such policy.

(3) "Nonpayment of premium" means the failure or inability of the named insured to discharge any obligation in connection with the payment of premiums on a policy of insurance subject to this regulation, whether such payments are payable directly to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit.

(4) "Nonrenewal" means termination of a policy at its expiration date.

(5) "Renewal" or "to renew" means the issuance of or the offer to issue by the insurer a policy succeeding a policy previously issued and delivered by the same insurer or an insurer within the same group of insurers, or the issuance of a certificate or notice extending the term of an existing policy for a specified period beyond its expiration date.

C.(1) If coverage has not been in effect for sixty days and the policy is not a renewal, cancellation shall be effected by mailing or delivering a written notice to the first-named insured at the mailing address shown on the policy at least sixty days before the cancellation effective date, except in cases where cancellation is based on nonpayment of premium. Notice of cancellation based on nonpayment of premium shall be mailed or delivered at least ten days prior to the effective date of cancellation. After coverage has been in effect for more than sixty days or after the effective date of a renewal policy, no insurer shall cancel a policy unless the cancellation is based on at least one of the following reasons:

(a) Nonpayment of premium.

(b) Fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy.

(c) Activities or omissions on the part of the named insured which change or increase any hazard insured against, including a failure to comply with loss control recommendations.

(d) Change in the risk which increases the risk of loss after insurance coverage has been issued or renewed, including an increase in exposure due to regulation, legislation, or court decision.

(e) Determination by the commissioner of insurance that the continuation of the policy would jeopardize a company's solvency or would place the insurer in violation of the insurance laws of this state or any other state.

(f) Violation or breach by the insured of any policy terms or conditions.

(g) Such other reasons that are approved by the commissioner of insurance.

(2)(a) A notice of cancellation of insurance coverage by an insurer shall be in writing and shall be mailed or delivered to the first-named insured at the mailing address as shown on the policy. Notices of cancellation based on R.S. 22:636.4(C)(1)(b) through (g) shall be mailed or delivered at least thirty days prior to the effective date of the cancellation; notices of cancellations based upon R.S. 22:636.4(C)(1)(a) shall be mailed or delivered at least ten days prior to the effective date of cancellation. The notice shall state the effective date of the cancellation.

(b) The insurer shall provide the first-named insured with a written statement setting forth the reason for the cancellation where the insured requests such a statement in writing and the named insured agrees in writing to hold the insurer harmless from liability for any communication giving notice of or specifying the reasons for a cancellation or for any statement made in connection with an attempt to discover or verify the existence of conditions which would be a reason for cancellation under this regulation.

(3) Nothing in this Section shall require an insurer to provide a notice of cancellation or a statement of reasons for cancellation where cancellation for nonpayment of premium is effected by a premium finance agency or other entity pursuant to a power of attorney or other agreement executed by or on behalf of the insured.

D.(1) An insurer may decide not to renew a policy if it delivers or mails to the first-named insured at the address shown on the policy written notice it will not renew the policy. Such notice of nonrenewal shall be mailed or delivered at least sixty days before the expiration date. Such notice to the insured shall include the insured's loss run information for the period the policy has been in force within, but not to exceed, the last three years of coverage. If the notice is mailed less than sixty days before expiration, coverage shall remain in effect under the same terms and conditions until sixty days after notice is mailed or delivered. Earned premium for any period of coverage that extends beyond the expiration date shall be considered pro rata based upon the previous year's rate. For purposes of this Section, the transfer of a policyholder between companies within the same insurance group shall not be a refusal to renew. In addition, changes in the deductible, changes in rate, changes in the amount of insurance, or reductions in policy limits or coverage shall not be refusals to renew.

(2) Notice of nonrenewal shall not be required if the insurer or a company within the same insurance group has offered to issue a renewal policy, or where the named insured has obtained replacement coverage or has agreed in writing to obtain replacement coverage.

(3) If an insurer provides the notice described in R.S. 22:636.4(D)(1) and thereafter the insurer extends the policy for ninety days or less, an additional notice of nonrenewal is not required with respect to the extension.

E.(1) An insurer shall mail or deliver to the named insured at the mailing address shown on the policy written notice of any rate increase, change in deductible, or reduction in limits or coverage at least thirty days prior to the expiration date of the policy. If the insurer fails to provide such thirty-day notice, the coverage provided to the named insured at the expiring policy's rate, terms, and conditions shall remain in effect until notice is given or until the effective date of replacement coverage obtained by the named insured, whichever first occurs. For the purposes of this Subsection, notice is considered given thirty days following date of mailing or delivery of the notice. If the insured elects not to renew, any earned premium for the period of extension of the terminated policy shall be calculated pro rata at the lower of the current or previous year's rate. If the insured accepts the renewal, the premium increase, if any, and other changes shall be effective the day following the prior policy's expiration or anniversary date.

(2) This Subsection shall not apply to the following:

(a) Changes in a rate or plan filed with the insurance rating commission and applicable to an entire class of business.

(b) Changes based upon the altered nature or extent of the risk insured.

(c) Changes in policy forms filed and approved with the commissioner and applicable to an entire class of business.

(d) Changes requested by the insured.

F. Proof of mailing of notice of cancellation, or of nonrenewal or of premium or coverage changes, to the named insured at the address shown in the policy, shall be sufficient proof of notice.

Acts 1987, No. 776, §1; Acts 1988, No. 677, §1; Acts 1991, No. 608, §1; Acts 1991, No. 798, §1; Acts 1993, No. 563, §1; Acts 2001, No. 1052, §1.

§636.5. Prohibited cancellation for nonpayment of premium

No insurer shall cancel any policy of insurance for nonpayment of premium to the insurer when the payment of such premium is made to the commissioner of insurance pursuant to the provisions of R.S. 22:737.1.

Acts 1989, No. 697, §1.

§636.6. Homeowner's insurance; cancellation, nonrenewal

A. An insurer that has issued a policy of homeowner's insurance shall not fail to renew the policy unless it has mailed or delivered to the named insured, at the address shown in the policy, written notice of its intention not to renew. The notice of nonrenewal shall be mailed or delivered at least thirty days before the expiration date of the policy. If the notice is mailed less than thirty days before expiration, coverage shall remain in effect under the terms and conditions until thirty days after the notice is mailed or delivered. Any earned premium for the period of coverage extended beyond the expiration date shall be considered pro rata based upon the rate of the previous year.

B. The notice of nonrenewal shall not be required if the insurer or a company within the same insurance group has offered to issue a renewal policy, or if the named insured has provided written notification to the insurer of the intention of the insured not to renew.

Acts 1991, No. 774, §1.

§636.7. Automobile liability coverage, medical payments

A policy of automobile liability insurance which provides for medical payments coverage shall not limit the time period during which the insured is entitled to payment or reimbursement for medical expenses incurred as a result of injuries caused by a covered accident when the injuries are diagnosed within one year of the accident and are reported to the insurer within three years of the accident.

Acts 1991, No. 807, §1.

§636.8. Overpayments; surplus premium; endorsement credits

All automobile insurers shall as soon as reasonably possible, but in no event later than thirty days, pay to the premium finance company, if the premium has been financed or if not financed, to the insured, or the person entitled thereto as shown by the automobile insurer's records any overpayment or surplus and commission paid or due on the policy. The failure to pay the person owed the money within the thirty-day period shall entitle that person to recover monetary penalties and interest. In the event the insured is due a credit from an endorsement or change to the policy, the return premium and commission shall be computed on a pro rata basis.

Acts 1997, No. 1428, §1.

§637. Cancellation by the insured; surrender

A. Cancellation by the insured of any policy which by its terms is cancellable at the insured's option or of any binder based on such policy may be effected by written notice thereof to the insurer and surrender of the policy or binder for cancellation prior to or on the effective date of such cancellation. In event the policy or binder has been lost or destroyed and cannot be so surrendered, the insurer may in lieu of such surrender accept and in good faith rely upon the insured's written statement setting forth the fact of such loss or destruction.

B. Within thirty days following such cancellation the insurer shall pay to the insured or to the person entitled thereto as shown by the insurer's records, any unearned portion of any premium paid on the policy as computed on the customary short rate or as otherwise specified in the policy, and any unearned commission. In the event the automobile insurance policy is canceled for nonpayment to the finance company, any unearned premium and commission shall be computed on a pro rata basis. If no premium has been paid on the policy, the insured shall be liable to the insurer for premium for the period during which the policy was in force.

C. The surrender of a policy to the insurer for any cause by any person named therein as having an interest insured thereunder shall create a presumption that such surrender is concurred in by all persons so named.

D. This Section shall not apply to life insurance policies or to annuity contracts, nor to the contracts provided in Part XV of this Chapter.

Acts 1958, No. 125; Acts 1991, No. 739, §1; Acts 1991, No. 790, §1; Acts 1997, No. 1428, §1.

§637.1. Interest on refund; exception

A. Any refund due an insured by an insurer writing or delivering insurance policies excluding health and life insurance, in the state because of either cancellation, elimination, or reduction of coverage by the insurer or the insured, shall be accompanied with interest at the rate of one and one-half percent per month of the amount of the refund due the customer, without the benefit of daily proration of this monthly interest, after thirty days of either of the following:

(1) The delivery to the insured of the written notice of such cancellation, elimination, or reduction;

(2) Delivery to the insurer's state, regional, or home office, from which such refund would issue, of the written request for such cancellation, elimination, or reduction. An insurer shall be deemed in compliance with this Section and not subject to the further accruement of interest by furnishing timely evidence of the mailing of such refund to the last known address of the insured.

B. The provisions of this Section shall not apply to those policies issued by an insurance company which require an audit.

Added by Acts 1977, No. 338, §1; Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996.

§638. Cancellation by the commissioner of insurance

The commissioner of insurance may order the immediate cancellation of any policy the procuring or effectuation of which was accomplished through or accompanied by a violation of this Code, except in cases where the policy by its terms is not cancellable by the insurer and the insured did not knowingly participate in any such violation.

Acts 1958, No. 125.

§639. Annulment of liability policies

No insurance contract insuring against loss or damage through legal liability for the bodily injury or death by accident of any individual, or for damage to the property of any person, shall be retroactively annulled by any agreement between the insurer and insured after the occurrence of any such injury, death, or damage for which the insured may be liable, and any such annulment attempted shall be void.

Acts 1958, No. 125.

§640. Dividends payable to the real party

A. Unless otherwise specified in the policy, every insurer issuing participating policies, shall pay dividends, unused premium refunds or savings distributed on account of any such policy, only to the real party in interest entitled thereto as shown by the insurer's records, or to any person to whom the right thereto has been assigned in writing of record with the insurer, or given in the policy by such real party in interest.

B. Any person who is shown by the insurer's records to have paid for his own account, or to have been ultimately charged for, the premium for insurance provided by a policy in which another person is the nominal insured, shall be deemed such real party in interest unless otherwise specified in the policy, proportionate to premium so paid or so charged. This Subsection shall not apply as to any such dividend, refund, or distribution which would amount to less than one dollar.

C. This Section shall not apply to contracts of group life insurance, group annuity, or group health and accident insurance, nor to policies issued prior to 12:00 noon of October 1, 1948.

Acts 1958, No. 125.

§641. Intervening breach

If any breach of a warranty or condition in any insurance contract occurs prior to a loss under the contract, such breach shall not avoid the contract nor avail the insurer to avoid liability, unless the breach exists at the time of the loss.

Acts 1958, No. 125.

§642. Assignment of policies

Subject to the terms of the policy relating to its assignment, life insurance policies, other than group life insurance policies and health and accident policies providing benefits for accidental death, whether such policies were heretofore or hereafter issued, and under the terms of which the beneficiary may be changed upon the sole request of the insured, may be assigned either by pledge or transfer of title, by an assignment executed by the insured alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer. This Section shall not prohibit the assignment by the insured of any certificate of insurance issued under a group life insurance policy. Any such assignment shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment, until the insurer has received at its home office written notice of termination of the assignment or pledge. No insurer shall prohibit the assignment to a viatical settlement provider of a policy otherwise assignable.

Acts 1958, No. 125. Amended by Acts 1966, No. 237, §1; Acts 2003, No. 124, §1.

§643. Payment discharges insurer

Whenever the proceeds of, or payments under a life endowment or health and accident insurance policy or any annuity contract issued by a life insurance company, heretofore or hereafter issued, become payable and the insurer makes payment thereof in accordance with the terms of the policy or contract or in accordance with any written assignment thereof or of any interest thereunder, hereafter made, the person then designated in the policy or contract or by such assignment as being entitled thereto, shall be entitled to receive such proceeds or payments and to give full acquittance therefor, and such payment shall fully discharge the insurer from all claims under the policy or contract unless, before payment is made, the insurer has received at its home office, written notice by or on behalf of some other person that such other person claims to be entitled to such payment or some interest in the policy or contract. Nothing contained in this Section shall affect any claim or right to any policy or contract or the proceeds thereof or payments thereunder as between persons other than the insurer.

Acts 1958, No. 125.

§644. Life insurance; prepayment of certain benefits

Rules and regulations concerning accelerated benefits relating to life insurance as provided in R.S. 22:6(1) shall be promulgated by the commissioner.

Acts 1991, No. 909, §1; Acts 1999, No. 1312, §1, eff. July 12, 1999.

§644.1. Life insurance and annuities; replacement

Rules and regulations concerning replacement of life insurance and annuities as provided in R.S. 22:6(1) shall be promulgated by the commissioner by July 1, 2000.

Acts 1999, No. 1312, §1, eff. July 12, 1999.

§645. Payments of proceeds; simultaneous deaths

Where the individual insured and the beneficiary designated in a life insurance policy or policy insuring against accidental death have died and there is not sufficient evidence that they have died otherwise than simultaneously, the proceeds of the policy shall be distributed as if the insured had survived the beneficiary, unless otherwise expressly provided in the policy.

Acts 1958, No. 125.

§646. Exemption of proceeds; health and accident

The proceeds or avails of all contracts of health and accident insurance and of provisions providing benefits on account of the insured's disability which are supplemental to life insurance or annuity contracts heretofore or hereafter effected shall be exempt from all liability for any debt of the insured, and from any debt of the beneficiary existing at the time the proceeds are made available for his use.

Acts 1958, No. 125.

§647. Exemption of proceeds; life, endowment, annuity

A.(1) The lawful beneficiary, assignee, or payee, including the insured's estate, of a life insurance policy or endowment policy, heretofore or hereafter effected shall be entitled to the proceeds and avails of the policy against the creditors and representatives of the insured and of the person effecting the policy or the estate of either, and against the heirs and legatees of either such person, and such proceeds and avails shall also be exempt from all liability for any debt of such beneficiary, payee, or assignee or estate, existing at the time the proceeds or avails are made available for his own use. For purposes of this Subsection, the proceeds and avails of the policy include the cash surrender value of the policy.

(2) The exemption authorized in Subsection (A)(1) from seizure under any writ, mandate, or process issued by any court of competent jurisdiction, including any bankruptcy proceedings, shall not apply to that portion of the cash surrender value, or loan value of any life insurance policy, endowment policy, or annuity contract payable upon surrender during the lifetime of the insured or annuitant which exceeds the sum of thirty-five thousand dollars if such policy or contract was issued within nine months of issuance of such writ, mandate, or process or the filing of a voluntary or involuntary bankruptcy proceeding under the United States Code. However, an insurer shall be liable only for such amounts that exceed the thirty-five thousand dollar exemption which are in the insurer's possession at the time the insurer receives, at its home office, written notice by or on behalf of a creditor of claims being made against such value or interest with specification of the amount claimed. The insurer shall have no obligation to determine the validity or the accuracy of the amount of the claim and shall be relieved of further liability of any kind with respect to the monies paid upon such request of a creditor. An insurer shall be entitled to be paid by preference and priority over the claim of any such seizing creditor the balance of any bona fide loan to such insured or owner which is secured by such interest or value in such policy or contract.

B.(1) The lawful beneficiary, assignee, or payee, including the annuitant's estate, of an annuity contract, heretofore or hereafter effected, shall be entitled to the proceeds and avails of the contract against the creditors and representatives of the annuitant or the person effecting the contract, or the estate of either, and against the heirs and legatees of either such person, saving the rights of forced heirs, and such proceeds and avails shall also be exempt from all liability for any debt of such beneficiary, payee, or assignee or estate, existing at the time the proceeds or avails are made available for his own use.

(2) The term "annuity contract" shall include any contract which:

(a) Is issued by a life insurance company licensed to provide the contract in the state in which it was issued at the time of issue.

(b) States on its face or anywhere within the terms of the contract that it is an "annuity" including but not limited to an immediate, deferred, fixed, equity indexed, or variable annuity, irrespective of current pay status or any other definition of "annuity" in Louisiana law.

(c) Provides the contract owner the ability to defer United States income taxes on any interest earned and not distributed to the owner.

(d) Transfers some risk of financial loss to the insurance company for financial consideration.

(e) Was approved as an annuity contract by the Department of Insurance of the state in which it was issued prior to issue.

C. The lawful beneficiary designated in an Education Assistance Account depositor's agreement to receive account funds in the event of the account owner's death, including the account owner's estate, of the funds contained in an Education Assistance Account established pursuant to R.S. 17:3095, heretofore or hereafter effected, shall be entitled to the proceeds and avails of the Education Assistance Account against the creditors and representatives of the account owner or the person effecting the account, or the estate of either, and against the heirs and legatees of either such person, saving the rights of forced heirs, and such proceeds and avails shall also be exempt from all liability for any debt of such beneficiary or estate existing at the time the proceeds and avails are made available for his own use.

D.(1) The provisions of Subsections A, B, and C of this Section shall apply:

(a) Whether or not the right to change the beneficiary is reserved or permitted in the policy, contract, or Education Assistance Account depositor's agreement.

(b) Whether or not the policy, contract, or Education Assistance Account depositor's agreement is made payable to the person whose life is insured, to his estate or to the estate of an annuitant or to the estate of an Education Assistance Account owner if the beneficiary, assignee or payee shall predecease such person.

(2) This Subsection shall not be construed so as to defeat any policy or contract provision which provides for disposition of proceeds in the event the beneficiary, assignee, or payee shall predecease the insured, annuitant, or Education Assistance Account owner.

E. No person shall be compelled to exercise any rights, powers, options, or privileges under any such policy, contract, or Education Assistance Account depositor's agreement.

F. There shall be excepted from the provisions of this Section a debt secured by a pledge of a policy, any rights under such policy that may have been assigned, and any advance payments made on or against such policy.

Acts 1958, No. 125; Acts 1987, No. 210, §1, eff. July 2, 1987; Acts 1990, No. 910, §1; Acts 1997, No. 1416, §2, eff. July 15, 1997; Acts 1999, No. 63, §3.

NOTE: SEE ACTS 1990, NO. 910, §2.

NOTE: See Acts 1999, No. 63, §4 regarding applicability.

§648. Policies payable to estate; effect of renunciation

In all policies of life or endowment insurance and in all annuity contracts where the estate of the insured or annuitant is a beneficiary or payee, the widow, or heir, or heirs of the insured or annuitant decedent shall be entitled to the proceeds of such policies or contracts according to the laws of distribution affecting the succession of the decedent even though they have renounced his succession with the same effect as if said renunciation had not taken place.

Acts 1958, No. 125.

§649. Exemption of proceeds; group life

A. A policy of group life insurance or the proceeds thereof payable to the individual insured or to beneficiary thereunder, shall not be liable, either before or after payment, to be applied to any legal or equitable process to pay any liability of any person having a right under the policy. The proceeds thereof, when not made payable to a named beneficiary or to a third person pursuant to a facility-of-payment clause, shall not constitute a part of the estate of the individual insured for the payment of his debts.

B. This Section shall not apply to group life insurance policies issued under R.S. 22:175(B)(4) (debtor groups) to the extent that such proceeds are applied to payment of the obligation for the purpose of which the insurance was so issued.

Acts 1958, No. 125.

§650. Forms for proof of loss furnished

Any insurer requiring completion of a proof of loss form shall furnish such form to any person claiming to have a loss under any insurance contract. But such insurer shall not, by reason of the requirement so to furnish forms, have any responsibility for or with reference to the completion of such proof or the manner of any such completion or attempted completion.

Acts 1958, No. 125; Acts 2003, No. 137, §1, eff. Jan. 1, 2004.

§651. Claim administration not waiver

None of the following acts by or on behalf of an insurer shall be deemed to constitute a waiver of any provision of a policy or of any defense of the insurer thereunder:

(1) Acknowledgment of the receipt of notice of loss or claim under the policy.

(2) Furnishing forms for reporting a loss or claim, for giving information relative thereto, or for making proof of loss, or receiving or acknowledging receipt of any such forms or proofs completed or incompleted.

(3) Investigating any loss or claim under any policy or engaging in negotiations looking toward a possible settlement of any such loss or claim.

Acts 1958, No. 125.

§652. Discrimination prohibited

No insurer shall make or permit any unfair discrimination in favor of particular individuals or persons, or between insureds or subjects of insurance having substantially like insuring risk, and exposure factors, or expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charged therefor, or in the benefits payable or in any other rights or privileges accruing thereunder. This provision shall not prohibit fair discrimination by a life insurer as between individuals having unequal life expectancies.

Acts 1958, No. 125.

§652.1. Discrimination in rates or failure to provide coverage because of severe disability or sickle cell trait prohibited

A. No insurance company shall charge unfair discriminatory premiums, policy fees or rates for, or refuse to provide any policy or contract of life insurance, life annuity, or policy containing disability coverage for a person solely because the applicant therefor has a severe disability, unless the rate differential is based on sound actuarial principles or is related to actual experience. No insurance company shall unfairly discriminate in the payments of dividends, other benefits payable under a policy, or in any of the terms and conditions of such policy or contract solely because the owner of the policy or contract has a severe disability.

B. "Severe disability", as used in this Section, means any disease of, or injury to, the spinal cord resulting in permanent and total disability, amputation of any extremity that requires prosthesis, permanent visual acuity of twenty/two hundred or worse in the better eye with the best correction, or a peripheral field so contracted that the widest diameter of such field subtends an angular distance no greater than twenty degrees, total deafness, inability to hear a normal conversation or use a telephone without the aid of an assistive device, or persons who have developmental disabilities, including but not limited to autism, cerebral palsy, epilepsy, mental retardation, and other neurological impairments.

C. Nothing in this Section shall be construed as requiring an insurance company to provide insurance coverage against a severe disability which the applicant or policyholder has already sustained.

D. No insurance company shall charge unfair discriminatory premiums, policy fees or rates for, or refuse to provide any policy or contract of life insurance, life annuity, or policy containing disability coverage for a person solely because the applicant therefor has sickle cell trait. No insurance company shall unfairly discriminate in the payments of dividends, other benefits payable under a policy, or in any of the terms and conditions of such policy or contract solely because the insured of the policy of contract has sickle cell trait. Nothing in this Subsection shall prohibit waiting periods, pre-existing conditions, or dreaded disease rider exclusions, or any combination thereof, if they do not unfairly discriminate.

Added by Acts 1981, No. 766, §1. Amended by Acts 1982, No. 643, §1.

§652.2. Discrimination in automobile liability insurance prohibited

A. No insurer shall refuse to issue or renew, increase the premium, or cancel an automobile insurance policy solely because the insured is deaf or hard of hearing, provided such person is mentally and physically capable of driving an automobile and possesses a valid Louisiana operator's license issued by the office of motor vehicles in the Louisiana Department of Public Safety and Corrections.

B. Where the owner of the covered vehicle has a physical or mental handicap that prevents him from operating his own motor vehicle, an insurance company issuing a policy of motor vehicle liability insurance shall not require the operator of the vehicle to carry liability insurance.

Added by Acts 1982, No. 285, §1; Acts 1993, No. 552, §1.

§652.3. Group life and health and accident policy; dependent coverage

A.(1) Every group, blanket, or association policy providing life insurance coverage and health and accident insurance coverage for dependents of the insured shall use the same criteria to determine the maximum age for eligibility of dependents for dependent life coverage as is used to determine the maximum age for eligibility of dependents for dependent health and accident coverage.

(2) When there is more than one insurance provider involved, the operational definition for dependent eligibility utilized by the medical coverage shall also be used for purposes of the life insurance coverage.

B. The provisions of this Section shall apply to all new policies issued after January 1, 1985. Any policies in effect on January 1, 1985, shall be amended to conform with this Section on the anniversary date of such coverage; however, such coverage shall take place no later than January 1, 1986.

Acts 1984, No. 558, §1, eff. Jan. 1, 1985; Acts 2003, No. 129, §1, eff. May 28, 2003.

§652.4. Discrimination; failure to provide coverage; penalties; right of action

A. No insurer shall refuse to issue or fail to renew any policy or contract of property and casualty insurance to a person or business, solely because of the race of the applicant or the economic condition of the area in which the property sought to be insured is located, unless such refusal to issue or failure to renew is based on sound actuarial principles or is related to actual experience.

B. Any insurer violating this Section shall be fined ten thousand dollars for each occurrence.

C. The commissioner of insurance shall promulgate rules and regulations necessary for the enforcement of this Section. The rules and regulations shall, at a minimum, provide a mechanism in which complaints concerning alleged discriminatory practices by insurers can be received and investigated. The rules and regulations shall also contain a provision allowing for an administrative hearing in accordance with the Administrative Procedure Act prior to the imposition of the penalty outlined in Subsection B of this Section.

D. Any person discriminated against in violation of this Section shall have a personal right of action against the insurer and may file suit against the insurer in a court of competent jurisdiction. Upon a finding of discrimination on the part of the insurer, the insurer shall be responsible for actual damages suffered by the injured party and reasonable attorney fees.

Acts 1993, No. 381, §1.

§653. Validity of noncomplying forms

Any insurance policy, rider, or endorsement hereafter issued and otherwise valid, which contains any condition or provision not in compliance with the requirements of this Code, shall not be rendered invalid thereby, but shall be construed and applied in accordance with such conditions and provisions as would have applied had such policy, rider or endorsement been in full compliance with this Code.

Acts 1958, No. 125.

§654. Construction of policies

Every insurance contract shall be construed according to the entirety of its terms and conditions as set forth in the policy, and as amplified, extended, or modified by any rider, endorsement, or application attached to or made a part of the policy.

Acts 1958, No. 125.

§655. Liability policy; insolvency or bankruptcy of insured and inability to effect service of citation or other process; direct action against insurer

A. No policy or contract of liability insurance shall be issued or delivered in this state, unless it contains provisions to the effect that the insolvency or bankruptcy of the insured shall not release the insurer from the payment of damages for injuries sustained or loss occasioned during the existence of the policy, and any judgment which may be rendered against the insured for which the insurer is liable which shall have become executory, shall be deemed prima facie evidence of the insolvency of the insured, and an action may thereafter be maintained within the terms and limits of the policy by the injured person, or his or her survivors, mentioned in Civil Code Art. 2315.1, or heirs against the insurer.

B.(1) The injured person or his or her survivors or heirs mentioned in Subsection A, at their option, shall have a right of direct action against the insurer within the terms and limits of the policy; and, such action may be brought against the insurer alone, or against both the insured and insurer jointly and in solido, in the parish in which the accident or injury occurred or in the parish in which an action could be brought against either the insured or the insurer under the general rules of venue prescribed by Code of Civil Procedure Art. 42 only. However, such action may be brought against the insurer alone only when:

(a) The insured has been adjudged a bankrupt by a court of competent jurisdiction or when proceedings to adjudge an insured a bankrupt have been commenced before a court of competent jurisdiction;

(b) The insured is insolvent;

(c) Service of citation or other process cannot be made on the insured;

(d) When the cause of action is for damages as a result of an offense or quasi-offense between children and their parents or between married persons;

(e) When the insurer is an uninsured motorist carrier; or

(f) The insured is deceased.

(2) This right of direct action shall exist whether or not the policy of insurance sued upon was written or delivered in the state of Louisiana and whether or not such policy contains a provision forbidding such direct action, provided the accident or injury occurred within the state of Louisiana. Nothing contained in this Section shall be construed to affect the provisions of the policy or contract if such provisions are not in violation of the laws of this state.

C. It is the intent of this Section that any action brought under the provisions of this Section shall be subject to all of the lawful conditions of the policy or contract and the defenses which could be urged by the insurer to a direct action brought by the insured, provided the terms and conditions of such policy or contract are not in violation of the laws of this state.

D. It is also the intent of this Section that all liability policies within their terms and limits are executed for the benefit of all injured persons and their survivors or heirs to whom the insured is liable; and, that it is the purpose of all liability policies to give protection and coverage to all insureds, whether they are named insured or additional insureds under the omnibus clause, for any legal liability said insured may have as or for a tort-feasor within the terms and limits of said policy.

Acts 1958, No. 125. Amended by Act 1962, No. 471, §1; Acts 1988, No. 934, §1, eff. Jan. 1, 1989; Acts 1989, No. 117, §2; Acts 1992, No. 584, §1. {{NOTE: SEE ACTS 1988, NO. 934, §2.}}

§656. Payment of claims; life policies; penalty

All death claims arising under policies of insurance issued or delivered within this state shall be settled by the insurer within sixty days after the date of receipt of due proof of death, and if the insurer fails to do so without just cause, the amount due shall bear interest at the rate of eight percent per annum from date of receipt of due proof of death by the insurer until paid.

Acts 1958, No. 125. Amended by Acts 1980, No. 477, §1.

§657. Payment of claims; health and accident policies; prospective review; penalties; self-insurers; telemedicine reimbursement by insurers

A. All claims arising under the terms of health and accident contracts issued in this state, except as provided in Subsection B, shall be paid not more than thirty days from the date upon which written notice and proof of claim, in the form required by the terms of the policy, are furnished to the insurer unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist. The insurer shall make payment at least every thirty days to the assured during that part of the period of his disability covered by the policy or contract of insurance during which the insured is entitled to such payments. Failure to comply with the provisions of this Section shall subject the insurer to a penalty payable to the insured of double the amount of the health and accident benefits due under the terms of the policy or contract during the period of delay, together with attorney's fees to be determined by the court. Any court of competent jurisdiction in the parish where the insured lives or has his domicile, excepting a justice of the peace court, shall have jurisdiction to try such cases.

B. All claims for accidental death arising under the terms of health and accident contracts where such contracts insure against accidental death shall be settled by the insurer within sixty days of receipt of due proof of death and should the insurer fail to do so without just cause, then the amount due shall bear interest at the rate of six percent per annum from date of receipt of due proof of death by the insurer until paid.

C. Any person, partnership, corporation or other organization, or the State of Louisiana which provides or contracts to provide health and accident benefit coverage as a self-insurer for his or its employees, stockholders or any other persons, shall be subject to the provisions of this Section, including the provisions relating to penalties and attorney fees, without regard to whether the person or organization is a commercial insurer provided, however, this Section shall not apply to collectively bargained union welfare plans other than health and accident plans.

D.(1) In any event where the contract between an insurer or self-insurer and the insured is issued or delivered in this state and contains a provision whereby in non-emergency cases the insured is required to be prospectively evaluated through a pre-hospital admission certification, pre-inpatient service eligibility program, or any similar pre-utilization review or screening procedure prior to the delivery of contemplated hospitalization, inpatient or outpatient health care, or medical services which are prescribed or ordered by a duly licensed health care provider who possesses admitting and clinical staff privileges at an acute care health care facility or ambulatory surgical care facility, the insurer, self-insurer, third party administrator, or independent contractor shall be held liable in damages to the insured only for damages incurred or resulting from unreasonable delay, reduction, or denial of the proposed medically necessary services or care according to the information received from the health care provider at the time of the request for a prospective evaluation or review by the duly licensed health care provider, as provided in the contract; which damages shall be limited solely to the physical injuries which are the direct and proximate cause of the unreasonable delay, reduction, or denial as further defined in this Subsection together with reasonable attorney fees and court costs.

(2)(a) Any insurer, health maintenance organization, preferred provider organization, or other managed care organization requirement that the insured be prospectively evaluated through a pre-hospital admission certification, pre-inpatient service eligibility program, or any similar pre-utilization review or screening procedure shall be inapplicable to an emergency medical condition.

(b) Every insurer, health maintenance organization, preferred provider organization, or other managed care organization which includes emergency medical services as part of its policy or contract, shall provide coverage and shall subsequently pay providers for emergency medical services provided to an insured, enrollee, or patient who presents himself with an emergency medical condition. This Subparagraph shall not be construed to require coverage for illnesses, conditions, diseases, equipment, supplies, or procedures or treatments which are not otherwise covered under the terms of the insured's policy or contract. The provisions of this Subparagraph shall not apply to hospital indemnity, disability, or renewable limited benefit supplemental health insurance policies authorized to be issued in this state.

(c) An insurer, health maintenance organization, preferred provider organization, or other managed care organization shall not retrospectively deny or reduce payments to providers for emergency medical services of an insured, enrollee, or patient even if it is determined that the emergency medical condition, initially presented is later identified through screening not to be an actual emergency, except in the following cases:

(i) Material misrepresentation, fraud, omission, or clerical error.

(ii) Any payment reductions due to applicable co-payments, co-insurance, or deductibles which may be the responsibility of the insured.

(iii) Cases in which the insured does not meet the emergency medical condition definition, unless the insured has been referred to the emergency department by the insured's primary care physician or other agent acting on behalf of the insurer.

(d) Every insurer, health maintenance organization, preferred provider organization, or other managed care organization shall inform its insureds, enrollees, patients, and affiliated providers about all applicable policies related to emergency care access, coverage, payment, and grievance procedures. It is the ultimate responsibility of the insurer, health maintenance organization, or preferred provider organization to inform any contracted third party administrator, independent contractor, or primary care provider about the emergency care provisions contained in this Paragraph.

(e) Failure to comply with the provisions of Subparagraphs (a), (b), and (c) shall subject the insurer, health maintenance organization, preferred provider organization, or other managed care organization to penalties as provided for in Subsection A of this Section and to penalties for violations as provided in R.S. 22:1217.

(f) The provisions of this Paragraph shall not apply to medical benefit plans that are established under and regulated by the Employment Retirement Income Security Act of 1974.

(g) As used in this Paragraph, the following definitions shall apply:

(i) "Emergency medical condition" is a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in:

(aa) Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.

(bb) Serious impairment to bodily function.

(cc) Serious dysfunction of any bodily organ or part.

(ii) "Emergency medical services" are those medical services necessary to screen, evaluate, and stabilize an emergency medical condition.

(iii) "Managed care organization" means a licensed insurance company, hospital or medical benefit plan or program, health maintenance organization, integrated health care delivery system, an employer or employee organization, or a managed care contractor which operates a managed care plan. A managed care organization may include but is not limited to a preferred provider organization, health maintenance organization, exclusive provider organization, independent practice association, clinic without walls, management services organization, managed care services organization, physician hospital organization, and hospital physician organization.

(iv) "Managed care plan" means a plan operated by a managed care entity which provides for the financing and delivery of health care and treatment services to individuals enrolled in such plan through its own employed health care providers or contracting with selected specific providers that conform to explicit selection, standards, or both. A managed care plan also customarily has a formal organizational structure for continual quality assurance, a certified utilization review program, dispute resolution, and financial incentives for individual enrollees to use the plan's participating providers and procedures.

(3)(a) For the purposes of this Subsection, a period of two working days from the time of the duly licensed health care provider's request to the insurer, self-insurer, third party administrator, or independent contractor for a pre-hospital admission or pre-inpatient service eligibility certification or any similar pre-utilization review or screening procedure confirmation until the receipt by the duly licensed health care provider of such insurer's, self-insurer's, third party administrator's, or independent contractor's certification, approval, or denial of the contemplated hospitalization, inpatient or outpatient health care, or medical services, shall not be considered unreasonable.

(b) For the purposes of this Subsection, a period in excess of two working days from the time of the duly licensed health care provider's request to the insurer, self-insurer, third party administrator, or independent contractor for a pre-hospital admission or pre-inpatient service eligibility certification or any similar pre-utilization review or screening procedure confirmation until the receipt by the duly licensed health care provider of such insurer's, self-insurer's, third party administrator's, or independent contractor's certification, approval, or denial of the contemplated hospitalization, inpatient or outpatient health care, or medical services may be considered unreasonable depending on the circumstances of each individual case.

(c) For the purposes of this Subsection, the term "unreasonable reduction" shall mean the decreasing or limiting of:

(i) Previously certified or approved health care or medical services as contracted for between the insurer and insured; or

(ii) Continued hospitalization and medical services without providing a procedure or method for certifying an extension of hospitalization and medical services by the insurer's or self-insurer's review or screening procedure in the event of continued hospitalization or medical attention, or both, as deemed medically necessary according to current established medical criteria.

(d) For the purposes of this Subsection an "unreasonable denial" shall mean the failure to:

(i) Review a request from a duly licensed health care provider by the insurer's or self-insurer's review or screening procedure; or

(ii) Review a request from the insured within the time period as provided for in the contract between the insurer or self-insurer and the insured, which time period shall not exceed two work days as provided for in Subparagraph 3(a); or

(iii) Deliver the contracted for health care or medical services previously certified or approved by the insurer's or self-insurer's review or screening procedure for medically necessary treatment or care as mandated by and provided for in the contract between the insurer or self-insurer and the insured; or

(iv) Review a request from a duly licensed health care provider by the insurer's or self-insurer's review or screening procedure for an extension of the original certified or approved duration of health care or medical services; or

(v) Extend the original certified or approved duration of hospitalization, health care or medical services requested by a duly licensed health care provider by the insurer's or self-insurer's review or screening procedure when treatment or care is deemed medically necessary according to current established medical criteria.

(e) For the purposes of this Subsection "medically necessary treatment or care", shall mean contemplated hospitalization, inpatient or outpatient health care or medical services recommended for appropriate treatment or care in accordance with nationally accepted current medical criteria.

(4) Any court of competent jurisdiction in the parish where the insured lives or has his domicile, excepting a justice of the peace court, has jurisdiction of cases arising under the provisions of Paragraph (1) of this Subsection.

E. No action for the recovery of penalties or attorney fees provided in this Section shall be brought after the expiration of one year after the date proofs of loss are required to be filed.

F.(1) Notwithstanding any provision of any policy or contract of insurance or health benefits issued after June 16, 1995, whenever such policy provides for payment, benefit, or reimbursement for any health care service, including but not limited to diagnostic testing, treatment, referral, or consultation, and such health care service is performed via transmitted electronic imaging or telemedicine, such a payment, benefit, or reimbursement under such policy or contract shall not be denied to a licensed physician conducting or participating in the transmission at the originating health care facility or terminus who is physically present with the individual who is the subject of such electronic imaging transmission and is contemporaneously communicating and interacting with a licensed physician at the receiving terminus of the transmission. The payment, benefit, or reimbursement to such a licensed physician at the originating facility or terminus shall not be less than seventy-five percent of the reasonable and customary amount of payment, benefit, or reimbursement which that licensed physician receives for an intermediate office visit.

(2) Any health care service proposed to be performed or performed via transmitted electronic imaging or telemedicine under this Subsection shall be subject to the applicable utilization review criteria and requirements of the insurer. Terminology in a health and accident insurance policy or contract that either discriminates against or prohibits such a method of transmitted electronic imaging or telemedicine shall be void as against public policy of providing the highest quality health care to the citizens of the state.

(3) The provisions of this Subsection shall not apply to individually underwritten limited benefit and supplemental health insurance policies authorized to be issued in the state.

G. REPEALED BY ACTS 1999, No. 1017, §2, eff. July 9, 1999.

Acts 1958, No. 125. Amended by Acts 1960, No. 287, §1; Acts 1979, No. 240, §1; Acts 1985, No. 429, §1; Acts 1989, No. 773, §1, eff. Jan. 1, 1990; Acts 1990, No. 872, §1, eff. July 25, 1990; Acts 1995, No. 391, §1, eff. June 16, 1995; Acts 1997, No. 846, §1, eff. July 10, 1997; Acts 1997, No. 1313, §1; Acts 1999, No. 1017, §2, eff. July 9, 1999.

NOTE: See Acts 1997, No. 1313, §3, for definition of health maintenance organization.

§658. Payment and adjustment of claims, policies other than life and health and accident; personal vehicle damage claims; penalties; arson-related claims suspension

A.(1) All insurers issuing any type of contract, other than those specified in R.S. 22:656, R.S. 22:657, and Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950, shall pay the amount of any claim due any insured within thirty days after receipt of satisfactory proofs of loss from the insured or any party in interest.

(2) All insurers issuing any type of contract, other than those specified in R.S. 22:656, R.S. 22:657, and Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950, shall pay the amount of any third party property damage claim and of any reasonable medical expenses claim due any bona fide third party claimant within thirty days after written agreement of settlement of the claim from any third party claimant.

(3) Except in the case of catastrophic loss, the insurer shall initiate loss adjustment of a property damage claim and of a claim for reasonable medical expenses within fourteen days after notification of loss by the claimant. In the case of catastrophic loss, the insurer shall initiate loss adjustment of a property damage claim within thirty days after notification of loss by the claimant. Failure to comply with the provisions of this Paragraph shall subject the insurer to the penalties provided in R.S. 22:1220.

(4) All insurers shall make a written offer to settle any property damage claim, including a third-party claim, within thirty days after receipt of satisfactory proofs of loss of that claim.

B.(1) Failure to make such payment within thirty days after receipt of such satisfactory written proofs and demand therefor or failure to make a written offer to settle any property damage claim, including a third-party claim, within thirty days after receipt of satisfactory proofs of loss of that claim, as provided in Paragraphs (A)(1) and (4), respectively, or failure to make such payment within thirty days after written agreement or settlement as provided in Paragraph (A)(2), when such failure is found to be arbitrary, capricious, or without probable cause, shall subject the insurer to a penalty, in addition to the amount of the loss, of twenty-five percent damages on the amount found to be due from the insurer to the insured, or one thousand dollars, whichever is greater, payable to the insured, or to any of said employees, or in the event a partial payment or tender has been made, twenty-five percent of the difference between the amount paid or tendered and the amount found to be due.

(2) The period set herein for payment of losses resulting from fire and the penalty provisions for nonpayment within the period shall not apply where the loss from fire was arson related and the state fire marshal or other state or local investigative bodies have the loss under active arson investigation. The provisions relative to time of payment and penalties shall commence to run upon certification of the investigating authority that there is no evidence of arson or that there is insufficient evidence to warrant further proceedings.

(3) The provisions relative to suspension of payment due to arson shall not apply to a bona fide lender which holds a valid recorded mortgage on the property in question.

(4) Whenever a property damage claim is on a personal vehicle owned by the third party claimant and as a direct consequence of the inactions of the insurer and the third party claimant's loss the third party claimant is deprived of use of the personal vehicle for more than five working days, excluding Saturdays, Sundays, and holidays, the insurer responsible for payment of the claim shall pay, to the extent legally responsible, for reasonable expenses incurred by the third party claimant in obtaining alternative transportation for the entire period of time during which the third party claimant is without the use of his personal vehicle. Failure to make such payment within thirty days after receipt of adequate written proof and demand therefor, when such failure is found to be arbitrary, capricious, or without probable cause shall subject the insurer to, in addition to the amount of such reasonable expenses incurred, a reasonable penalty not to exceed ten percent of such reasonable expenses or one thousand dollars whichever is greater together with reasonable attorneys fees for the collection of such expenses.

C.(1) All claims brought by insureds, worker's compensation claimants, or third parties against an insurer shall be paid by check or draft of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or his attorney, or upon direction of such claimant to one specified; provided, however, that the check or draft shall be made jointly to the claimant and the employer when the employer has advanced the claims payment to the claimant. Such check or draft shall be paid jointly until the amount of the advanced claims payment has been recovered by the employer.

(2) No insurer shall intentionally or unreasonably delay, for more than three calendar days, exclusive of Saturdays, Sundays, and legal holidays, after presentation for collection, the processing of any properly executed and endorsed check or draft issued in settlement of an insurance claim.

(3) Any insurer violating this Subsection shall pay the insured or claimant a penalty of two hundred dollars or fifteen percent of the face amount of the check or draft, whichever is greater.

D.(1) When making a payment incident to a claim, no insurer shall require that as a condition to such payment, repairs be made to a motor vehicle, including window glass repairs or replacement, in a particular place or shop or by a particular entity. Any insurer violating the provisions of this Subsection shall be fined not more than five hundred dollars for each offense.

(2) A violation of this Subsection shall constitute an additional ground, under R.S. 22:1142, for the commissioner to refuse to issue a license or to suspend or revoke a license issued to any agent, broker, or solicitor to sell insurance in this state.

Acts 1958, No. 125; Acts 1985, No. 778, §1; Acts 1986, No. 132, §1, eff. June 26, 1986; Acts 1988, No. 398, §1; Acts 1989, No. 638, §1; Acts 1990, No. 262, §1, eff. July 4, 1990; Acts 1990, No. 955, §1; Acts 1992, No. 879, §1; Acts 1993, No. 163, §1; Acts 1993, No. 585, §1, H.C.R. No. 4, 2002 1st Ex. Sess.; Acts 2003, No. 790, §1

{{**NOTE**: SEE ACTS 1989, NO. 638, §2.}}

§658.1. Failure to timely satisfy claim under criminal bond contract

A. Any prosecuting attorney may file with the commissioner of insurance's office a rule to show cause if all the following are true:

(1) A judgment of bond forfeiture has been rendered after June 22, 1993, against the commercial surety underwriter.

(2) Proper notice pursuant to R.S. 15:85 has been mailed.

(3) No suspensive appeal has been taken.

(4) The defendant has neither been surrendered nor appeared within six months of mailing of the notice of the signing of the judgment of bond forfeiture.

(5) More than six months has lapsed from the mailing of the proper notice of the signing of the judgment of bond forfeiture.

(6) The judgment of bond forfeiture has not been satisfied by payment.

B. The prosecuting attorney shall attach adequate documentation to support his affidavit and submit it to the commissioner of insurance.

C.(1) The commissioner of insurance shall within ten days of receipt of the request for rule to show cause issued by the prosecuting attorney send notice to the commercial surety underwriter setting a date for a rule to show cause not less than three days nor more than ten days from the issuance of the commissioner's notice. At the rule to show cause, the commissioner may consider only issues which would interrupt the enforceability of the judgment.

(2) The commissioner shall order the commercial surety underwriter to pay immediately the judgment of bond forfeiture, if the commissioner finds that all of the following are true:

(a) A judgment of bond forfeiture has been rendered after June 22, 1993, against the commercial surety underwriter.

(b) Proper notice pursuant to R.S. 15:85 has been mailed.

(c) No suspensive appeal has been taken.

(d) The defendant has neither been surrendered nor appeared within six months of mailing of the notice of the signing of the judgment of bond forfeiture.

(e) More than six months has lapsed from the mailing of the proper notice of the signing of the judgment of bond forfeiture.

(f) The judgment of bond forfeiture has not been satisfied by payment.

D. The burden of proof at the hearing shall be upon the commercial surety by a preponderance of evidence and shall be limited to documents contained in the official court record where the judgment was rendered. The surety company may use evidence not contained in the record to show that it did not receive post-forfeiture notice or the post-forfeiture notice required pursuant to R.S. 15:85 was not properly mailed.

E. A commercial surety shall pay an administrative fine of five hundred dollars to the Department of Insurance for each hearing to show cause in which the commercial surety is a named party when the judgment has been paid after the issuance of a rule to show cause that meets the requirements of Subsection A of this Section.

Acts 1993, No. 834, §5, eff. June 22, 1993; Acts 1999, No. 1151, §1, eff. July 9, 1999.

§659. Hospitalization insurance, exclusion of payments to medical facilities owned or operated by state or for services reimbursed by medical assistance

A. No policy of hospitalization insurance shall be issued after August 31, 1968, by any insurer doing business in this state which excludes payment of benefits to an insured for services rendered to the insured by a medical facility owned or operated by the state of Louisiana or any of its political subdivisions, whether it be a general hospital, a mental hospital, a tubercular hospital, or a geriatric hospital. Any policy provision in violation of this Subsection shall be invalid.

B. No policy of hospitalization insurance shall be issued by any insurer doing business in this state which excludes payment of benefits to an insured or his assignee for services rendered by a physician, hospital, or other provider of medical services, which services are considered reimbursable in whole or in part from federal or state medical assistance funds provided pursuant to Title XIX of the Social Security Act and R.S. 46:153. Any payment in excess of actual charges for such services shall be reimbursed to the appropriate federal or state medical assistance fund by the person or establishment receiving such excess payment.

Added by Acts 1958, No. 246, §1. Amended by Acts 1968, No. 462, §1; Acts 1980, No. 822, §1.

§660. Premium to be shown on power of attorney attached to bail bond

No power of attorney shall be attached to a bail bond unless the premium as defined by R.S. 22:627, charged for the bail bond is shown thereon.

Added by Acts 1964, No. 135, §1.

§661. Motor vehicle liability policy

No settlement made under a motor vehicle liability insurance policy of a claim against any insured thereunder arising from any accident or other event insured against for damage to or destruction of property owned by another person shall be construed as an admission of liability by the insured, or the insurer's recognition of such liability, with respect to any other claim arising from the same accident or event.

Added by Acts 1966, No. 348, §1.

§662. Reimbursement for services, podiatrist

Notwithstanding any other provision of law to the contrary, whenever any contract of insurance or any medical or hospital and medical service contract issued or delivered in this state provides for reimbursement of any services which are within the lawful scope of practice of a duly licensed podiatrist as defined in R.S. 37:611 reimbursement under such contract directly to the person rendering the services shall not be denied when such service is rendered by a person so licensed.

Added by Acts 1972, No. 754, §1.

§663. Hospitalization, accident and health insurance; reduction of benefits prohibited

Notwithstanding any other provisions in this title to the contrary, no group policy of accident, health or hospitalization insurance, or of any group combination of these coverages, shall be issued by any insurer doing business in this state which by the terms of such policy group contract excludes or reduces the payment of benefits to or on behalf of an insured by reason of the fact that benefits have been paid under any other individually underwritten contract or plan of insurance for the same claim determination period. Any group policy provision in violation of this section shall be invalid.

Added by Acts 1972, No. 342, §1.

§664. Visual services, choice of practitioners

Whenever any contract of insurance or any medical or hospital service contract or hospital and medical service contract issued or delivered in this state provides for reimbursement of any visual services which are within the lawful scope of practice of a duly licensed optometrist as defined in R.S. 37:1041, the insured or other person entitled to benefits under such contract shall be entitled to reimbursements for such services, whether such services are performed by a duly licensed physician or a duly licensed optometrist, notwithstanding any provision of the law to the contrary or any provision in any such contract; duly licensed optometrist shall be entitled to participate in such contracts providing for visual services to the same extent as duly licensed physicians. There shall be no discrimination in the amount of reimbursement allowed for such visual services, whether performed by an optometrist or physician, in instances where the services performed are within the lawful scope of practice of both professions.

Added by Acts 1972, No. 60, §1.

§665. Hospital and medical expense policies; services of licensed psychologists

A. Whenever any hospital or medical expense policy or hospital or medical service contract issued, or issued for delivery in this state provides for the reimbursement of health related services that can lawfully be performed by a duly licensed psychologist as regulated under the provisions of R.S. 37:2351-2368, the insured or other person entitled to benefits under such contract shall be entitled to reimbursements for such services performed by a duly licensed psychologist notwithstanding any provisions of the contract to the contrary.

B. The provisions of Subsection A of this section shall apply only to those insurance policy contracts issued or issued for delivery after the effective date of this section.

C. The provisions of this section shall apply only to those services which a duly licensed psychologist is authorized to perform under the provisions of Chapter 28 of Title 37 of the Louisiana Revised Statutes of 1950. D. Nothing in this section shall be construed to mandate or require an insurance company to include mental health services in a contract, or to expand the scope or nature of benefits provided, when such benefits are included in a contract.

Added by Acts 1974, No. 481, §§1 to 3.

§666. Waiver of subrogation

Under any policy of insurance which authorizes the insured to waive the right of recovery of the insured against any party prior to loss without additional premium, the insured shall also be entitled to waive in writing after loss without invalidating the policy the right of recovery against any of the following:

(1) Anyone insured under the same policy;

(2) A corporation, partnership or other entity in which the insured owns stock or has a proprietary interest;

(3) Anyone who owns stock or has a proprietary interest in the insured;

(4) An employee or employer of the insured;

(5) Anyone having an interest as owner, lessor or lessee of the insured premises or the premises on which the loss occurred and the employees, partners and stockholders of such owner, lessor or lessee; and

(6) Any relative by blood or marriage of the insured. The insurer shall be entitled to recover from the insured any compensation received by the insured for such waiver after loss not to exceed the amount paid to the insured for such loss by the insurer.

Added by Acts 1974, No. 435, §1.

§667. Personal property; specific coverage; valuation; exemptions

A. In any case in which a policy includes coverage for loss of or damage to personal property of the insured, from whatever cause, if the insurer places a valuation upon the specific item of covered property and uses such valuation for purposes of determining the premium charge to be made under the policy, the insurer shall compute any covered loss of or damage to such property which occurs during the term of the policy at such valuation without deduction or offset, unless a different method is to be used in the computation of loss, in which latter case, the policy, and any application therefor, shall set forth in type of prominent size, the actual method of such loss computation by the insurer.

B.(1) The provisions of this Section shall not apply to any of the following:

(a) Insurance of the kind referred to in R.S. 22:6(3) when the coverage pertains to land vehicles;

(b) Any property used primarily for business purposes; or

(c) Insurance on a group of items insured as contents insurance on household items, unless specifically insured under Subsection A of this Section.

(2) However, nothing in this Subsection shall be so construed as to classify horses, breed bulls, show cattle, or registered dogs as being purchased or owned primarily for business purposes.

Added by Acts 1974, No. 578, §1; Acts 1985, No. 985, §1.

§668. Selection of type of treatment; reimbursement

A.(1) Notwithstanding any provision of any policy or contract of insurance or health benefits issued after the effective date of this Section, whenever such policy or contract provides for payment or reimbursement for any service, and such service may be legally performed by a chiropractor licensed in this state, such payment or reimbursement under such policy or contract shall not be denied when such service is rendered by a person so licensed. Terminology in such policy or contract deemed discriminatory against any such person or method of practice shall be void.

(2) The provisions of this Section shall apply to all new policies issued on or after November 1, 1975. Any insurer who, on August 1, 1975, has health and accident policies in force shall, upon the anniversary date of such policies, convert all existing policies to conform to the provisions of this Section; provided, however, that all existing policies shall be converted to conform to the provisions of this Section by August 1, 1976.

B. Any person, partnership, corporation, or other organization or the state of Louisiana which provides or contracts to provide health and accident benefit coverage as a self-insurer for his or its employees, stockholders, or other persons shall be subject to the provisions of this Section. This Section shall not apply to collectively bargained union welfare plans, other than health and accident plans.

C. The provisions of this Subsection* shall apply to all new policies issued on or after December 1, 1984. Any insurer who on December 1, 1984, has health and accident policies in force shall convert upon the anniversary date of such policies all existing policies to conform to the provisions of Subsection B of this Section. All existing policies shall be converted to conform to the provisions of Subsection B of this Section no later than December 1, 1985.

Added by Acts 1975, No. 265, §1, eff. Nov. 1, 1975. Acts 1984, No. 680, §1.

*As appears in enrolled Act.

§669. Severe mental illness and other mental disorders; policy provisions; minimum requirements; group, blanket, and association policies

A.(1)(a) Any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or other agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type in this state, including a group insurance plan, a self-insurance plan, and the Office of Group Benefits programs, delivered or issued for delivery in this state on or after January 1, 2000, shall include benefits payable for the treatment of severe mental illness under the same circumstances and conditions or greater as benefits are paid under those policies, contracts, benefit plans, agreements, or programs for all other diagnoses, illnesses, or accidents.

(b) For purposes of this Section, "severe mental illness" shall include any of the following diagnosed severe mental illnesses:

(i) Schizophrenia or schizoaffective disorder.

(ii) Bipolar disorder.

(iii) Pervasive developmental disorder or autism.

(iv) Panic disorder.

(v) Obsessive-compulsive disorder.

(vi) Major depressive disorder.

(vii) Anorexia/bulimia.

(viii) Asperger's Disorder.

(ix) Intermittent explosive disorder.

(x) Posttraumatic stress disorder.

(xi) Psychosis NOS (not otherwise specified) when diagnosed in a child under seventeen years of age.

(xii) Rett's Disorder.

(xiii) Tourette's Disorder.

(2)(a) Any issuer of a group, blanket, or association policy, contract, benefit plan, agreement, or program specified in Paragraph (1) of this Subsection shall also offer to the policyholder an optional provision in the policy, contract, benefit plan, agreement, or program which states that benefits shall be payable for the treatment of mental disorders other than severe mental illness as defined in Paragraph (1) under the same circumstances and conditions as benefits are paid under those policies, contracts, benefit plans, agreements, or programs for all other diagnoses, illnesses, or accidents.

(b) If the policyholder elects not to purchase this optional coverage, the issuer shall not be required to notify the policyholder in any renewal, reinstatement, or modified policy, contract, benefit plan, agreement, or program as to the availability of the optional coverage. However, the policyholder may request the optional coverage in writing on any anniversary date of the policy, contract, benefit plan, agreement, or program.

(3)(a) The provisions of this Section shall apply only to group, blanket, and association policies.

(b) The provisions of this Section shall not apply to individually underwritten health insurance plans; short term, limited duration health insurance policies; and individually underwritten limited benefit and supplemental health insurance policies.

(4) These benefits shall be payable when the treatment or services are rendered by a physician licensed under the provisions of R.S. 37:1261 et seq., psychologist licensed under the provisions of R.S. 37:2351 et seq., or when the treatment or services are rendered by a licensed clinical social worker licensed under the provisions of R.S. 37:2701 et seq., who is a member of a national clinical social work registry.

(5) A policy, contract, benefit plan, agreement, or program shall be in compliance with the requirements of Paragraph (1) of this Subsection if it includes the following benefits:

(a) Forty-five inpatient days per covered individual per calendar year. However, a policy, contract, benefit plan, agreement, or program may provide a method to allow a covered individual to exchange two days of partial hospitalization or two days of residential treatment center hospitalization for each inpatient day of treatment.

(b) Fifty-two outpatient visits per covered individual per calendar year, including the intensive outpatient program. However, a policy, contract, benefit plan, agreement, or program may provide a method to allow a covered individual to exchange one inpatient day of treatment for four outpatient visits or exchange four outpatient visits for one inpatient day of treatment.

B. Whenever any such policies, contracts, programs, or plans provide for the reimbursement of health-related services that can be lawfully performed by a licensed clinical social worker, licensed under the provisions of R.S. 37:2701 et seq., the insured or other person entitled to benefits under such policy, contract, program, or plan shall be entitled to reimbursement for such services performed by a board-certified social worker notwithstanding any provisions of the policy, contract, program, or plan to the contrary.

C. No policy, contract, benefit plan, agreement, or program issued or entered into pursuant to this Section shall contain any provision for a waiting period in excess of sixty days from its effective date before benefits are payable for the treatment of severe mental illness or other mental disorders.

D. Nothing in this Section shall be construed to prohibit management of the provision of benefits for mental disorders through such methods as preadmission screening prior to the authorization of services or any other mechanism designed to limit coverage for services for mental disorders only to those deemed medically necessary by a licensed mental health professional.

Added by Acts 1981, No. 411, §1, eff. Jan. 1, 1982; Acts 1985, No. 213, §1; Acts 1999, No. 1285, §1, No. 1309, §4; Acts 2001, No. 1178, §2, eff. June 29, 2001; Acts 2003, No. 129, §1, eff. May 28, 2003; Acts 2004, No. 51, §1.

§670. Premises used as polling places; prohibited provisions excluding or limiting coverage

A. A provision in a liability or other insurance policy which excludes or limits coverage solely because premises are being used as a polling place in an election shall be null and shall be void and unenforceable as contrary to public policy.

B. The provisions of Subsection A shall apply to policies of insurance issued after July 6, 1988.

Acts 1988, No. 257, §1, eff. July 6, 1988.

§671. Automobile liability coverage; loaner vehicle; driver's policy primary policy

A. Notwithstanding any provision of the policy, the primary liability, physical damage, or collision coverage for a loaner vehicle shall be the policy of the driver, not the policy of the vehicle sales or service dealer who provided the loaner vehicle.

B.(1) In this Section, "loaner vehicle" means any vehicle which is provided to an insured driver by a vehicle sales or service dealer for his temporary use as a replacement vehicle while the insured's vehicle is being serviced or repaired. The term shall also mean any vehicle which is provided to an insured driver by a vehicle service or sales dealer for the purpose of allowing the driver to demonstrate or test drive the vehicle.

(2) In this Section, "vehicle sales or service dealer" means any person engaged in the business of selling, repairing, or servicing motor vehicles.

Acts 1988, No. 756, §1; Acts 1997, No. 1060, §1.

§672. Towing and storage of motor vehicles; insurance policies; storage fees; exceptions

A. An automobile insurance policy shall not be construed to allow an insurer to assume or accede to the legal title of a motor vehicle without assuming credit obligations of the insured owner of the motor vehicle for charges for towing and storage services associated with the incident from which the insurance coverage arises. Such charges for storage services shall not exceed any maximum charge set by the Public Service Commission pursuant to its legal authority under R.S. 45:180.1, or as otherwise provided by law.

B. An insurer which has succeeded to the title of a motor vehicle is not authorized to abandon such vehicle to a towing or storage service without consent of the provider of such service.

C.(1) A debt incurred by or on behalf of a named insured for towing or storage services may be collected from an insurer which succeeds to the legal title of the motor vehicle covered under the policy for physical damage, property damage, or uninsured motorist coverage.

(2) An insurer may be authorized by the provisions of an automobile insurance policy to act for a named insured in any matter regarding the towing and storage of a covered disabled vehicle.

D.(1) REPEALED BY ACTS 1999, No. 1108, §3, eff. Jan. 1, 2000.

(2) Any storage facility which charges and receives a fee in excess of that set in this Section shall return all storage fees received for storage of the vehicle for which an excess fee was charged and shall be subject to a fine not to exceed one hundred dollars. Each daily overcharge shall constitute a separate violation for which a fine may be assessed.

(3) The daily storage fee shall be the only fee charged by the storage facility during storage of a vehicle. There shall be no additional charges for locating the vehicle in the storage facility, viewing of the vehicle, photography of the vehicle, removal of items from the vehicle, or for any other similar activity which does not require towing or moving of the vehicle during regular business hours.

(4) Nothing in this Section shall be construed to diminish the authority of the Public Service Commission to regulate wreckers and towing services and their rates, fares, tolls, or charges as provided by R.S. 45:180.1.

(5) For the purposes of this Section "inside" shall be limited to storage in or under a fixed structure.

E. Nothing in this Section shall apply to any of the following as defined by R.S. 32:1:

(1) Bus or large passenger vehicle.
(2) Combination of vehicles.
(3) Freight-carrying vehicle.
(4) Mobile home.
(5) Road tractor.
(6) School bus (Type I or II).
(7) Semi-trailer.
(8) Tandem truck.
(9) Trailer.
(10) Truck.
(11) Truck-tractor.

Acts 1990, No. 951, §§1, 3; Acts 1992, No. 375, §1; Acts 1999, No. 1108, §§1, 3 (§3 eff. Jan. 1, 2000).

§673. Damaged vehicle in storage facility; timely appraisal; penalties

A. Whenever a property damage claim on a personal vehicle is made by an insured or a third party claimant, and the damaged vehicle is located in a storage facility, the insurer responsible for payment of the claim shall cause an appraisal of the damaged vehicle to be made within ten working days of the date of notification of the location and availability of the vehicle. In the event the property damage is caused by a natural disaster or catastrophe or unusual circumstances, the appraisal requirement in this Section shall be twenty working days.

B. Failure to make an appraisal within such time shall subject the insurer to a penalty, in addition to any other amounts owed, of ten percent of the value of the vehicle as determined by subsequent appraisal, or one thousand dollars, whichever is greater, payable to the insured or third party together with any appraisal fee, and all reasonable attorney fees incurred as a result of a violation of this Section.

Acts 1992, No. 867, §1.

§674. Proceeds from health care payments; notice to patient, creditor

A. Any entity, including a health care provider as defined by R.S. 40:1299.41, receiving health insurance payments from a health insurer or other payor of health care benefits shall provide written notice to the patient, policyholder, or insured of the receipt of the payment within ten working days of receipt of a written request for such notice by certified mail.

B.(1) The person who is entitled to receipt of the payment may file suit to recover the monies due, plus attorney fees and court costs. Such suit may be filed no sooner than thirty days after the payment has been posted to the account of the health care provider.

(2) Nothing in this Section shall affect the right of subrogation by the insurer or health care provider.

(3) The notice requirement to the patient, policyholder, or insured shall not apply if the health insurer or other payor of health care benefits making payments to the health care provider sends notification of payment to the patient, policyholder, or insured.

Acts 1997, No. 1385, §1.

§675. Stop-loss insurance coverage

A. Stop-loss coverage shall be defined as insurance covering the loss of an insured above a specific amount or a self-insurer for losses over a stated amount.

B. Any insurer authorized to issue property and casualty or health and accident policies of insurance in this state shall report, with its annual statement, any premiums written in this state for stop-loss or excess insurance coverage to the Department of Insurance in the manner prescribed by the commissioner.

C. A stop-loss or excess insurance policy form intended for issue to cover losses of a group health plan, as defined in R.S. 22:250.1(1), shall be submitted to the Department of Insurance for prior approval pursuant to the policy form filing requirements established by R.S. 22:620 and shall satisfy the following conditions:

(1) The stop-loss or excess insurance policy shall be issued to and insure the group health plan or the plan itself and not the employees, members, or participants.

(2) Payments by the insurer shall be made to the sponsor of the group health plan or the plan itself and not the employees, members, participants, or providers.

(3) The specific stop-loss or excess limit or attachment point per individual claimant shall be at least ten thousand dollars. The aggregate stop-loss or excess limit or attachment point for the group health plan shall be, at a minimum, one hundred twenty percent of the group health plan's total expected claims per policy period.

(4) The stop-loss or excess insurance policy shall contain a provision stating that the bankruptcy or insolvency of the insured shall not relieve the stop-loss carrier from its obligation under R.S. 22:655(A).

(5)(a) The stop-loss or excess insurance policy shall contain a provision that eligible claims incurred under the group health plan during the initial contract period shall be covered, provided that proof of payment by the plan is furnished to the insurer within ninety days after the expiration of the policy or any later period that is provided in the contract or insurance policy.

(b) All applications for stop-loss or excess insurance must include the option to purchase coverage extending, for at least ninety days beyond the expiration of the contract term, the period within which claims incurred during the contract term must be submitted and paid.

(c) All applications for stop-loss or excess insurance that include the option to purchase a policy providing coverage restricted to claims both incurred and paid during the contract term must contain a form for acceptance or rejection of the offer mandated in Subparagraph (5)(b) and must include disclosures as prescribed by the commissioner.

(d) All applications for stop-loss or excess insurance including options to purchase a policy providing coverage for claims incurred prior to the contract term, or providing coverage for claims incurred prior to the contract term but paid during the contract term, must contain a form for acceptance or rejection of the offer mandated in Subparagraph (5)(b) and must include disclosures as prescribed by the commissioner.

(6) The stop-loss or excess insurance policy shall provide coverage with rates not subject to adjustment by the stop-loss insurer during the policy period, unless any of the following occur:

(a) There is a change in the benefits provided under the group health plan.

(b) Enrollment under the group health plan changes by at least ten percent.

(7) The stop-loss or excess insurance policy form filed with the Department of Insurance for approval shall contain a separate document certifying that each of the requirements specified in Paragraphs (1) through (6) of this Subsection have been met.

D. Stop-loss or excess insurance shall not be equivalent to reinsurance, as reinsurance only relates to transactions between insurers. An entity purporting to cover a self-insured group health plan shall be treated as a stop-loss or excess insurer and shall be subject to the insurance laws and regulations of the state relating to such insurers and to penalties for violations of such laws and regulations. In no instance shall stop-loss or excess loss insurance be defined as a contract or policy of health insurance under R.S. 22:3002(1)(a).

E. Insurance companies writing stop-loss or excess insurance coverage shall exercise due diligence in ascertaining the legitimacy or authority of the underlying group health plan before issuing coverage. This shall include but not be limited to ensuring that the underlying plan is not a self-insured multiple employer welfare arrangement, as defined in 29 U.S.C. §1002(40) unless the underlying plan is a self-insurance plan as defined in R.S. 22:3002(1) and is authorized to do business in this state as a self-insurer.

F. Provider stop-loss or excess insurance policies that protect health care providers from a portion of the financial risk assumed in managed care contracts with health and accident insurers, health maintenance organizations, and self-insured group plans shall be submitted to the Department of Insurance for approval and shall satisfy the following conditions:

(1) The stop-loss or excess insurance policy shall be issued to and insure the contracted provider or network of health care providers.

(2) Payments by the insurer shall be made to the contracted provider or network of health care providers.

(3) The individual stop-loss amount, that is, retention or attachment point per claimant, shall be at least five thousand dollars. The aggregate stop-loss or excess amount shall be, at a minimum, fifty thousand dollars per calendar year.

(4) The stop-loss or excess insurance policy shall contain a provision that the proof of loss shall be furnished to the insurer within ninety days after the date that loss is incurred or any later period that is provided in the contract or insurance policy.

(5) Filings of a stop-loss or excess insurance policy filed with the Department of Insurance for approval shall contain a separate document certifying that each of the requirements specified in Paragraphs (1) through (4) of this Subsection have been met.

G. A stop-loss or excess insurance policy form covering any other kind of loss, damage, or liability may only be written by a property and casualty insurer and shall satisfy the following conditions:

(1) The stop-loss or excess insurance policy shall be issued to and insure an individual or business against legal liabilities other than those associated with provision of health benefits to employees or members of a health benefit plan or managed care health plan.

(2) Payments by the insurer shall be made to the insured upon provision of proof of loss.

Acts 2001, No. 273.§1, eff. June1, 2001; Acts 2003, No. 140, §1.

§676. Automobile insurance; total loss provision

An insurer may use the cost to repair or replace airbags used or damaged in an automobile accident to determine if the automobile is a total loss under the total loss provisions of the insurance policy if the policyholder agrees in writing. As used in this Section a "total loss" provision is any provision in an automobile insurance contract that allows the insurer to purchase the vehicle from the insured in lieu of paying for damages to the vehicle. Nothing in this Section shall require an insurer to pay more than the actual cash value of the vehicle, including the value of the air bags.

Added by Acts 2005, No. 262, §1.

§§677. – §679. [Blank]
§680. Uninsured motorist coverage

The following provisions shall govern the issuance of uninsured motorist coverage in this state:

(1)(a)(i) No automobile liability insurance covering liability arising out of the ownership, maintenance, or use of any motor vehicle shall be delivered or issued for delivery in this state with respect to any motor vehicle designed for use on public highways and required to be registered in this state or as provided in this Section unless coverage is provided therein or supplemental thereto, in not less than the limits of bodily injury liability provided by the policy, under provisions filed with and approved by the commissioner of insurance, for the protection of persons insured thereunder who are legally entitled to recover nonpunitive damages from owners or operators of uninsured or underinsured motor vehicles because of bodily injury, sickness, or disease, including death resulting therefrom; however, the coverage required under this Section is not applicable when any insured named in the policy either rejects coverage, selects lower limits, or selects economic-only coverage, in the manner provided in Item (1)(a)(ii) of this Section. In no event shall the policy limits of an uninsured motorist policy be less than the minimum liability limits required under R.S. 32:900, unless economic-only coverage is selected as authorized herein. Such coverage need not be provided in or supplemental to a renewal, reinstatement, or substitute policy when the named insured has rejected the coverage or selected lower limits in connection with a policy previously issued to him by the same insurer or any of its affiliates. The coverage provided under this Section may exclude coverage for punitive or exemplary damages by the terms of the policy or contract. Insurers may also make available, at a reduced premium, the coverage provided under this Section with an exclusion for all noneconomic loss. This coverage shall be known as "economic-only" uninsured motorist coverage. Noneconomic loss means any loss other than economic loss and includes but is not limited to pain, suffering, inconvenience, mental anguish, and other noneconomic damages otherwise recoverable under the laws of this state.

(ii) Such rejection, selection of lower limits, or selection of economic-only coverage shall be made only on a form prescribed by the commissioner of insurance. The prescribed form shall be provided by the insurer and signed by the named insured or his legal representative. The form signed by the named insured or his legal representative which initially rejects such coverage, selects lower limits, or selects economic-only coverage shall be conclusively presumed to become a part of the policy or contract when issued and delivered, irrespective of whether physically attached thereto. A properly completed and signed form creates a rebuttable presumption that the insured knowingly rejected coverage, selected a lower limit, or selected economic-only coverage. The form signed by the insured or his legal representative which initially rejects coverage, selects lower limits, or selects economic-only coverage shall remain valid for the life of the policy and shall not require the completion of a new selection form when a renewal, reinstatement, substitute, or amended policy is issued to the same named insured by the same insurer or any of its affiliates. An insured may change the original uninsured motorist selection or rejection on a policy at any time during the life of the policy by submitting a new uninsured motorist selection form to the insurer on the form prescribed by the commissioner of insurance. Any changes to an existing policy, regardless of whether these changes create new coverage, except changes in the limits of liability, do not create a new policy and do not require the completion of new uninsured motorist selection forms. For the purpose of this Section, a new policy shall mean an original contract of insurance which an insured enters into through the completion of an application on the form required by the insurer.

(iii) This Subparagraph and its requirement for uninsured motorist coverage shall apply to any liability insurance covering any accident which occurs in this state and involves a resident of this state.

(iv) Notwithstanding any contrary provision of this Section and R.S. 22:1406, an automobile liability policy written to provide coverage for a school bus may limit the scope of uninsured motorist liability to only provide liability coverage for damages incurred by reason of an accident or incident involving the school bus, or a temporary substitute vehicle, and such limitation shall limit the uninsured motorist coverage of a named insured in the policy to only damages incurred by reason of such accident or incident.

(b) Any insurer delivering or issuing an automobile liability insurance policy referred to herein shall also permit the insured, at his written request, to increase the coverage applicable to uninsured motor vehicles provided for herein to any available limit up to the bodily injury liability coverage limits afforded under the policy.

(c)(i) If the insured has any limits of uninsured motorist coverage in a policy of automobile liability insurance, in accordance with the terms of Subparagraph (1)(a) of this Section, then such limits of liability shall not be increased because of multiple motor vehicles covered under said policy of insurance, and such limits of uninsured motorist coverage shall not be increased when the insured has insurance available to him under more than one uninsured motorist coverage provision or policy; however, with respect to other insurance available, the policy of insurance or endorsement shall provide the following:

(ii) With respect to bodily injury to an injured party while occupying an automobile not owned by said injured party, resident spouse, or resident relative, the following priorities of recovery under uninsured motorist coverage shall apply:

(aa) The uninsured motorist coverage on the vehicle in which the injured party was an occupant is primary;

(bb) Should that primary uninsured motorist coverage be exhausted due to the extent of damages, then the injured occupant may recover as excess from other uninsured motorist coverage available to him. In no instance shall more than one coverage from more than one uninsured motorist policy be available as excess over and above the primary coverage available to the injured occupant.

(d) Unless the named insured has rejected uninsured motorist coverage, the insurer issuing an automobile liability policy that does not afford collision coverage for a vehicle insured thereunder shall, at the written request of a named insured, provide coverage in the amount of the actual cash value of such motor vehicle described in the policy or ten thousand dollars, whichever is less, for the protection of persons insured thereunder who are legally entitled to recover damages from the owner or operator of an uninsured motor vehicle because of property damage to the motor vehicle described in the policy arising out of the operation, maintenance, or use of the uninsured motor vehicle. The coverage provided under this Section shall be subject to a deductible in an amount of two hundred fifty dollars for any one accident. The coverage provided under this Section shall not provide protection for any of the following:

(i) Damage where there is no actual physical contact between the covered motor vehicle and an uninsured motor vehicle, unless the injured party can show, by an independent and disinterested witness, that the injury was the result of the actions of the driver of another vehicle whose identity is unknown or who is uninsured or underinsured.

(ii) Loss of use of a motor vehicle.

(iii) Damages which are paid or payable under any other property insurance.

(e) The uninsured motorist coverage does not apply to bodily injury, sickness, or disease, including death of an insured resulting therefrom, while occupying a motor vehicle owned by the insured if such motor vehicle is not described in the policy under which a claim is made, or is not a newly acquired or replacement motor vehicle covered under the terms of the policy. This provision shall not apply to uninsured motorist coverage provided in a policy that does not describe specific motor vehicles.

(f) Uninsured motorist coverage shall include coverage for bodily injury arising out of a motor vehicle accident caused by an automobile which has no physical contact with the injured party or with a vehicle which the injured party is occupying at the time of the accident, provided that the injured party bears the burden of proving, by an independent and disinterested witness, that the injury was the result of the actions of the driver of another vehicle whose identity is unknown or who is uninsured or underinsured.

(2)(a) For the purpose of this coverage, the terms "uninsured motor vehicle" shall, subject to the terms and conditions of such coverage, be deemed to include an insured motor vehicle where the liability insurer thereof is unable to make payment with respect to the legal liability of its insured within the limits specified therein because of insolvency.

(b) For the purposes of this coverage the term uninsured motor vehicle shall, subject to the terms and conditions of such coverage, also be deemed to include an insured motor vehicle when the automobile liability insurance coverage on such vehicle is less than the amount of damages suffered by an insured and/or the passengers in the insured's vehicle at the time of an accident, as agreed to by the parties and their insurers or as determined by final adjudication.

(3) Any party possessing a certificate of self-insurance as provided under the Louisiana Motor Vehicle Safety Responsibility Law, shall be an "insurer" within the meaning of uninsured motorist coverage provided under the provisions of this Section. This provision shall not be construed to require that a party possessing a certificate of self-insurance provide uninsured motorist coverage or that such coverage is provided by any party possessing such a certificate.

(4) In the event of payment to any person under the coverage required by this Section and R.S. 22:1406 and subject to the terms and conditions of such coverage, the insurer making such payment shall, to the extent thereof, be entitled to the proceeds of any settlement or judgment resulting from the exercise of any rights of recovery of such person against any person or organization legally responsible for the bodily injury for which such payment is made, including the proceeds recoverable from the assets of the insolvent insurer.

(5) The coverage required under this Section may include provisions for the submission of claims by the assured to arbitration; provided, however, that the submission to arbitration shall be optional with the assured, shall not deprive the assured of his right to bring action against the insurer to recover any sums due him under the terms of the policy, and shall not purport to deprive the courts of this state of jurisdiction of actions against the insurer.

(6) In any action to enforce a claim under the uninsured motorist provisions of an automobile liability policy the following shall be admissible as prima facie proof that the owner and operator of the vehicle involved did not have automobile liability insurance in effect on the date of the accident in question:

(a) The introduction of sworn notarized affidavits from the owner and the operator of the alleged uninsured vehicle attesting to their current addresses and declaring that they did not have automobile liability insurance in effect covering the vehicle in question on the date of the accident in question. When the owner and the operator of the vehicle in question are the same person, this fact shall be attested to in a single affidavit.

(b) A sworn notarized affidavit by an official of the Department of Public Safety and Corrections to the effect that inquiry has been made pursuant to R.S. 32:871 by depositing the inquiry with the United States mail, postage prepaid, to the address of the owner and operator as shown on the accident report, and that neither the owner nor the operator has responded within thirty days of the inquiry, or that the owner or operator, or both, have responded negatively as to the required security, or a sworn notarized affidavit by an official of the Department of Public Safety and Corrections that said department has not or cannot make an inquiry regarding insurance. This affidavit shall be served by certified mail upon all parties fifteen days prior to introduction into evidence.

(c) Any admissible evidence showing that the owner and operator of the alleged uninsured vehicle was a nonresident or not a citizen of Louisiana on the date of the accident in question, or that the residency and citizenship of the owner or operator of the alleged uninsured vehicle is unknown, together with a sworn notarized affidavit by an official of the Department of Public Safety and Corrections to the effect that on the date of the accident in question, neither the owner nor the operator had in effect a policy of automobile liability insurance.

(d) The effect of the prima facie evidence referred to in (a), (b) and (c) above is to shift the burden of proof from the party or parties alleging the uninsured status of the vehicle in question to their uninsured motorist insurer.

(7) REPEALED BY ACTS 2003, No. 456, §2.

Acts 2003, No. 456, §§1, 2, and 3.

§681. Coverage of temporary, substitute, and rental vehicles

Every approved insurance company, reciprocal or exchange, writing automobile liability, physical damage, or collision insurance, shall extend to temporary substitute motor vehicles as defined in the applicable insurance policy and rental private passenger automobiles any and all such insurance coverage in effect in the original policy or policies. Where an insured has coverage on multiple vehicles, at least one of which has comprehensive and collision insurance coverage, that comprehensive and collision substitute coverage shall apply to the temporary substitute motor vehicle or rental motor vehicle. Such insurance shall be primary. However, if other automobile insurance coverage is purchased by the insured for the temporary substitute or rental motor vehicle, that coverage shall become primary. The coverage purchased by the insured shall not be considered a collateral source.

Acts 2003, No. 456, §3.

PART XV. STANDARD FIRE POLICY

§691. Fire insurance contract; standard provisions; variations

A. The printed form of a policy of fire insurance, as set forth in Subsection F shall be known and designated as the "standard fire insurance policy of the State of Louisiana."

B. No policy or contract of fire insurance shall be made, issued or delivered by any insurer, or by any agent or representative thereof, on any property in this state, unless it shall conform as to all provisions, stipulations, agreements and conditions, with such form of policy.

There shall be printed at the head of said policy the name of the insurer or insurers issuing the policy; the location of the home office thereof; a statement whether said insurer or insurers are stock or mutual corporations or are reciprocal insurers or Lloyds underwriters or, if organized under a special charter, a statement of such fact and the plan under which such insurer operates in this state; and there may be added thereto such device or devices as the insurer or insurers issuing said policy shall desire.

The standard fire insurance policy provided for herein need not be used for effecting reinsurance between insurers.

If the policy is issued by a mutual, co-operative or reciprocal insurer having special regulations with respect to the payment by the policyholder of assessments, such regulations shall be printed upon the policy, and any such insurer may print upon the policy such regulations as may be appropriate to or required by its home state or its form of organization.

C. Binders or other contracts for temporary insurance may be made, orally or in writing, and shall be deemed to include all the terms of such standard fire insurance policy and all such applicable endorsements, not disapproved by the office of property and casualty as may be designated in such contract of temporary insurance; except that the cancellation clause thereof specifying the hour of the day at which the insurance shall commence, may be superseded by the express terms of such contract of temporary insurance.

D. Two or more insurers authorized to do in this state the business of fire insurance, may, with the approval of the commissioner of insurance, issue a combination standard form of fire insurance policy which shall contain the following provisions:

(1) A provision substantially to the effect that the insurers executing such policy shall be severally liable for the full amount of any loss or damage, according to the terms of the policy, or for specified percentages or amounts thereof, aggregating the full amount of such insurance under such policy.

(2) A provision substantially to the effect that service of process, or of any notice or proof of loss required by such policy, upon any of the insurers executing such policy, shall be deemed to be service upon all such insurers.

E.(1) Appropriate forms of other contracts or endorsements whereby the interest in the property described in such policy shall be insured against one or more of the perils which the insurer is empowered to assume, in addition to the perils covered by said standard fire insurance policy, may be approved and may, unless at any time disapproved by the office of property and casualty, be used in connection with a standard fire insurance policy and such forms may contain provisions and stipulations inconsistent with the standard policy if applicable only to such other perils. The first page of the policy may, in a form approved by the office of property and casualty, be rearranged to provide space for the listing of amounts of insurance, rates and premiums for the basic coverages insured under the standard form of policy and for additional coverages or perils insured under endorsements attached, and such other data as may be conveniently included for duplication on daily reports for office records.

(2) Any policy or contract otherwise subject to the provisions of Subsections A and B hereof, which includes either on an unspecified basis as to the coverage or for a single premium, coverage against the peril of fire and substantial coverage against other perils need not comply with the provisions of Subsections A and B hereof, provided (1) such policy or contract shall afford coverage, with respect to the peril of fire, not less than the coverage afforded by said standard fire policy, (2) the provisions in relation to mortgagee interests and obligations in said standard fire policy may be incorporated therein without change, (3) such policy or contract is complete as to all of its terms without reference to the standard form of fire insurance policy or any other policy, and (4) the commissioner is satisfied that such policy or contract complies with the provisions hereof. The pages of the Standard Fire Insurance Policy may be renumbered and the format rearranged for convenience in the preparation of individual contracts, and to provide space for the listing of rates and premiums for coverages insured thereunder or under endorsement attached or printed thereon, and such other data as may be conveniently included for duplication on daily reports for office records.

F. The form of the standard fire insurance policy of the state of Louisiana (with permission to substitute for the word "company" a more accurate descriptive term for the type of insurer) shall be as follows:

(1) FIRST PAGE OF STANDARD FIRE POLICY

No.

(Space for insertion of name of company or companies issuing the policy and other matter permitted to be stated at the head of the policy.)

(Space for listing amounts of insurance, rates and premiums for the basic coverages insured under the standard form of policy and for additional coverages or perils insured under endorsements attached.)

In consideration of the provisions and stipulations herein or added hereto and of _____ dollars premium this company, for the term of _____ from the _____ day of _____ 19 ___, to the _____ day of _____ 19___, at 12:01 A.M. Standard Time, at location of property involved, to an amount not exceeding _____ dollars, does insure _____ and legal representatives, to the extent of the actual cash value of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss, without allowance for any increased cost of repair or reconstruction by reason of any ordinance or law regulating construction or repair, and without compensation for loss resulting from interruption of business or manufacture, nor in any event for more than the interest of the insured, against all DIRECT LOSS BY FIRE, LIGHTNING AND BY REMOVAL FROM PREMISES ENDANGERED BY THE PERILS INSURED AGAINST IN THIS POLICY, EXCEPT AS HEREINAFTER PROVIDED, to the property described hereinafter while located or contained as described in this policy, or pro rata for five days at each proper place to which any of the property shall necessarily be removed for preservation from the perils insured against in this policy, but not elsewhere.

Assignment of this policy shall not be valid except with the written consent of this Company.

This policy is made and accepted subject to the foregoing provisions and stipulations and those hereinafter stated, which are hereby made a part of this policy, together with such other provisions, stipulations and agreements as may be added hereto, as provided in this policy.

IN WITNESS WHEREOF, this Company has executed and attested these presents at _____.

_____
(signature of officer)

Signed this _____ day of _____, 19___.

_____
AGENT

(2) SECOND PAGE OF STANDARD FIRE POLICY

Concealment, fraud -- This entire policy shall be void if, whether before or after a loss, the insured has willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto.

Uninsurable and excepted property -- This policy shall not cover accounts, bills, currency, deeds, evidence of debt, money or securities; nor, unless specifically named hereon in writing, bullion or manuscripts.

Perils not included -- This company shall not be liable for loss by fire or other perils insured against in this policy caused, directly or indirectly, by:

(a) enemy attack by armed forces, including action taken by military, naval or air forces in resisting an actual or an immediately impending enemy attack; (b) invasion; (c) insurrection; (d) rebellion; (e) revolution; (f) civil war; (g) usurped power; (h) order of any civil authority except acts of destruction at the time of and for the purpose of preventing the spread of fire, provided that such fire did not originate from any of the perils excluded by this policy; (i) neglect of the insured to use all reasonable means to save and preserve the property at and after a loss, or when the property is endangered by fire in neighboring premises; (j) nor shall this Company be liable for loss by theft.

Other insurance -- Other insurance may be prohibited or the amount of insurance may be limited by endorsement attached hereto.

Conditions suspending or restricting insurance. Unless otherwise provided in writing added hereto, this Company shall not be liable for loss occurring:

(a) While the hazard is increased by any means within the control or knowledge of the insured; or

(b) While a described building, whether intended for occupancy by owner or tenant, is vacant, or unoccupied beyond a period of sixty consecutive days; or

(c) As a result of explosion or riot, unless fire ensue, and in that event for loss by fire only.

Other perils or subjects -- Any other peril to be insured against or subject of insurance to be covered in this policy shall be by endorsement in writing hereon or added hereto.

Added provisions -- The extent of the application of insurance under this policy and of the contribution to be made by this Company in case of loss, and any other provision or agreement not inconsistent with the provisions of this policy, may be provided for in writing added hereto, but no provisions may be waived except such as by the terms of this policy is subject to change.

Waiver provisions -- No permission affecting this insurance shall exist, or waiver of any provision be valid unless granted herein or expressed in writing added hereto. No provision, stipulation, or forfeiture shall be held to be waived by any requirement or proceeding on the part of this Company relating to appraisal or to any examination provided for herein.

Cancellation of policy -- This policy shall be canceled at any time at the request of the insured, in which case this Company shall, upon demand and surrender of this policy, refund the excess of paid premium above the customary short rates for the expired time. This policy may be canceled at any time by this Company by giving to the insured a thirty days written notice of cancellation, or ten days written notice when cancellation is for nonpayment of premium, with or without tender of the excess paid premium above the pro rata premium for the expired time which excess, if not tendered, shall be refunded on demand. Notice of cancellation shall state that said excess premium, if not tendered, will be refunded on demand. Upon the written request of the named insured, the insurer shall provide to the insured in writing the reasons for cancellation of the policy. There shall be no liability on the part of and no cause of action of any nature shall arise against any insurer or its agents, employees, or representatives for any action taken by them to provide the reasons for cancellation as required by this Paragraph.

Mortgagee interest and obligations -- If loss hereunder is made payable in whole or in part, to a designated mortgagee not named herein as the insured, such interest in this policy may be canceled by delivering or mailing to such mortgagee a thirty days written notice of cancellation, or a ten days written notice of cancellation if cancellation is for nonpayment of premium.

If the insured fails to render proof of loss such mortgagee, upon notice, shall render proof of loss in form herein specified within sixty (60) days thereafter and shall be subject to the provisions hereof relating to appraisal and time of payment and of bringing suit. If this Company shall claim that no liability existed as to the mortgagor or owner, it shall, to the extent of payment of loss to the mortgagee, be subrogated to all the mortgagee's rights of recovery, but without impairing mortgagee's rights to sue; or it may pay off the mortgage debt and require an assignment thereof and of the mortgage. Other provisions relating to the interests and obligations of such mortgagee may be added hereto by agreement in writing.

Pro rata liability -- This Company shall not be liable for a greater proportion of any loss than the amount hereby insured shall bear to the whole insurance covering the property against the peril involved, whether collectible or not.

Requirements in case loss occurs -- The insured shall give immediate written notice to this Company of any loss, protect the property from further damage, forthwith separate the damaged and undamaged personal property, put it in the best possible order, furnish a complete inventory of the destroyed, damaged, and undamaged property, showing in detail quantities, costs, actual cash value, and amount of loss claimed; and within sixty days after loss, unless such time is extended in writing by this Company, the insured shall render to this Company a proof of loss, signed and sworn to by the insured, stating the knowledge and belief of the insured as to the following: the time and origin of the loss, the interest of the insured and of all others in the property, the actual cash value of each item thereof and the amount of loss thereto, all encumbrances thereon, all other contracts of insurance, whether valid or not, covering any of said property, any changes in the title, use, occupation, location, possession, or exposures of said property since the issuing of this policy, by whom and for what purpose any building herein described and the several parts thereof were occupied at the time of loss and whether or not it then stood on leased ground, and shall furnish a copy of all the descriptions and schedules in all policies and, if required, verified plans and specifications of any building, fixtures, or machinery destroyed or damaged. The insured, as often as may be reasonably required shall exhibit to any person designated by this Company all that remains of any property herein described, and submit to examinations under oath by any person named by this Company, and subscribe the same; and, as often as may be reasonably required, shall produce for examination all books of account, bills, invoices and other vouchers, or certified copies thereof if originals be lost, at such reasonable time and place as may be designated by this Company or its representatives, and shall permit extracts and copies thereof to be made.

Appraisal -- In case the insured and this Company shall fail to agree as to the actual cash value or the amount of loss, then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within twenty days of such demand. The appraisers shall first select a competent and disinterested umpire; and failing for fifteen days to agree upon such umpire, then on request of the insured or this Company such umpire shall be selected by a judge of a court of record in the state in which the property covered is located. The appraisers shall then appraise the loss, stating separately actual cash value and loss to each item; and failing to agree, shall submit their differences, only, to the umpire. An award in writing, so itemized, of any two when filed with this Company shall determine the amount of actual cash value and loss. Each appraiser shall be paid by the party selecting him and the expenses of appraisal and umpire shall be paid by the parties equally.

Company's options -- It shall be optional with this Company to take all, or any part, of the property at the agreed or appraised value, and also to repair, rebuild, or replace the property destroyed or damaged with other of like kind and quality within a reasonable time, on giving notice of its intention so to do within thirty days after the receipt of the proof of loss herein required.

Abandonment -- There can be no abandonment to this Company of any property.

When loss payable -- The amount of loss for which this Company may be liable shall be payable thirty days after proof of loss, as herein provided, is received by this Company and ascertainment of the loss is made either by agreement between the insured and this Company expressed in writing or by filing with this Company of an award as herein provided.

Suit -- No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law or equity unless all the requirements of this policy shall have been complied with, and unless commenced within twelve months next after the inception of the loss.

Subrogation -- This Company may require from the insured an assignment of all right of recovery against any party for loss to the extent that payment therefor is made by this Company.

(3) THIRD PAGE OF STANDARD FIRE POLICY

Attach Form Below This Line
BACK OF STANDARD FIRE POLICY
(Optional)
Standard Fire Insurance Policy of the State of Louisiana

Expires _____
Property _____
Assured _____
No. _____
(Company)

It is important that the written portions of all policies covering the same property read exactly alike. If they do not, they should be made uniform at once.

G. Insurers issuing a standard fire policy pursuant to this Section are hereby authorized to affix thereto or include therein a written statement that the policy does not cover loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination, all whether directly or indirectly resulting from an insured peril under said policy; provided, however, that nothing herein contained shall be construed to prohibit the attachment to any such policy of an endorsement or endorsements specifically assuming coverage for loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination.

H. For the purposes of commercial property and casualty insurance policies, the standard policy of fire insurance prescribed by this Part shall not cover loss or damage caused, directly or indirectly, by terrorism, unless an endorsement specifically assuming coverage for loss or damage caused by terrorism is attached to the policy. Insurers issuing commercial property and casualty insurance policies against the peril of fire and other perils permitted under this Section are hereby authorized to add to the policy by endorsement or include within the policy statement that the policy does not cover such loss.

Acts 1958, No. 125. Amended by Acts 1960, No. 193, §1; Acts 1960, No. 194, §1; Acts 1977, No. 335, §1; Acts 1985, No. 938, §1, eff. Jan. 1, 1986; Acts 1987, No. 510, §1; Acts 1989, No. 657, §1; Acts 1999, No. 882, §1, eff. July 2, 1999; Acts 2003, No. 1133, §1.

§691.1. Forms to be furnished

Upon receiving notice of loss from the insured, the insurer on the policy or contract of fire insurance shall furnish within thirty days to the insured a form suitable for filing a proof of loss and shall advise the insured that he is required under the terms of the policy or contract of fire insurance to submit a proof of loss.

Added by Acts 1977 No. 202, §1.

§691.2. Fire insurance contract; standard provisions; variations

A. Notwithstanding the requirements of R.S. 22:691 concerning the use of the standard fire policy, the use of such form shall not be required in the event the policy forms covering the peril of fire are equivalent to or exceed the provisions of the standard fire policy.

B. In the event that the policy forms used are not equivalent to or do not exceed the terms of the standard fire policy, all of the provisions of the standard fire policy shall become a part of the policy by physically attaching the standard fire policy thereto.

C. Failure to attach the standard fire policy as provided in R.S. 22:691.2(B) shall not affect the rights of the insured under the standard fire policy and the provisions of the standard fire policy shall become a part of the contract and shall prevail.

Acts 1986, No. 133, §1, eff. June 26, 1986; Acts 2004, No. 34, §1.

§692. Breach of warranties and conditions of fire policies and applications therefor

No policy of fire insurance issued by any insurer on property in this state shall hereafter be declared void by the insurer for the breach of any representation, warranty or condition contained in the said policy or in the application therefor. Such breach shall not avail the insurer to avoid liability unless such breach (1) shall exist at the time of the loss, and be either such a breach as would increase either the moral or physical hazard under the policy, or (2) shall be such a breach as would be a violation of a warranty or condition requiring the insurer to take and keep inventories and books showing a record of his business. Notwithstanding the above provisions of this Section, such a breach shall not afford a defense to a suit on the policy if the fact or facts constituting such a breach existing at the time of the issuance of the policy and were, at such time, known to the insurer or to any of his or its officers or agents, or if the fact or facts constituting such a breach existed at the time of the loss and were, at such time, known to the insurer or to any of his or its officers or agents, except in case of fraud on the part of such officer or agent or the insured, or collusion between such officer or agent and the insured.

Acts 1958, No. 125.

§692.1. Defense of material misrepresentation not entitlement to void policy

Assertion of a defense of material misrepresentation made by an insured subsequent to loss by fire as to the value of the contents of a residence or business shall not entitle an insurer to void total coverage of the policy based on such misrepresentation, unless a court of competent jurisdiction determines and adjudicates otherwise.

Acts 1985, No. 506, §1.

§693. Suits on fire insurance policies

Whenever suit is filed to recover loss on a fire insurance policy which has been issued either in the name of a married man or a married woman on property belonging to the community of acquets and gains or on property which is the separate and paraphernal property of either husband or wife, it shall not be a good defense on the part of the insurer, except in case of fraud to allege that the policy was issued in the name of the husband, whereas the title to the property was in the name of the wife or vice versa; or that the policy was issued in the name of the husband, whereas the property was the separate and paraphernal property of the wife or vice versa, any contract to the contrary notwithstanding.

The insurer shall have the burden and duty of issuing the policy in the name of the real owner of the property covered by such policy.

Acts 1958, No. 125.

§694. Co-insurance clauses; prohibited in certain cases

No policy of fire, lightning or windstorm insurance covering property or risks in this state shall contain any clause or provisions requiring the insured to take out or maintain a larger amount of insurance than that covered by such policy or providing in any way that the insured shall be liable as a co-insurer with the insured unless such clause has been approved by the fire insurance division and there has been a consideration allowed in the rate of premium charged for such policy.

Acts 1958, No. 125. Amended by Acts 1960, No. 330, §1; Acts 1963, No. 115, §1.

§695. Valued policy clause; exceptions

A. Under any fire insurance policy insuring inanimate, immovable property in this state, if the insurer places a valuation upon the covered property and uses such valuation for purposes of determining the premium charge to be made under the policy, in the case of total loss the insurer shall compute and indemnify or compensate any covered loss of, or damage to, such property which occurs during the term of the policy at such valuation without deduction or offset, unless a different method is to be used in the computation of loss, in which latter case, the policy, and any application therefor, shall set forth in type of equal size, the actual method of such loss computation by the insurer. Coverage may be voided under said contract in the event of criminal fault on the part of the insured or the assigns of the insured.

B. Any clause, condition, or provision of a policy of fire insurance contrary to the provisions of this Section shall be null and void, and have no legal effect. Nothing contained herein shall be construed to prevent any insurer from cancelling or reducing, as provided by law, the insurance on any property prior to damage or destruction.

C. The liability of the insurer of a policy of fire insurance, in the event of total or partial loss, shall not exceed the insurable interest of the insured in the property unless otherwise provided for by law. Nothing in this Section shall be construed as to preclude the insurer from questioning or contesting the insurable interest of the insured.

D. This Section shall only apply to policies issued or renewed after January 1, 1992, and shall not apply to a loss covered by a blanket-form policy of insurance nor to a loss covered by a builders risk policy of insurance.

Acts 1991, No. 850, §1; Acts 1995, No. 737, §1.

PART XVI. REHABILITATION, LIQUIDATION, CONSERVATION, DISSOLUTION, AND ADMINISTRATIVE SUPERVISION

§731. REPEALED BY ACTS 1995, No. 595, §2, eff. June 18, 1995.

§732. Scope of Part

This Part shall apply to all insurers or persons purporting to be doing an insurance business in this state or in the process of organization for the purpose of doing or attempting to do such business, including but not limited to insurers who issue policies of life, health, and accident insurance in the state.

Acts 1958, No. 125; Acts 1991, No. 997, §1; Acts 1995, No. 595, §1, eff. June 18, 1995.

§732.1. Persons covered

The proceedings authorized by this Part shall be applied to:

(1) All insurers who are doing, or have done, an insurance business in this state and against whom claims arising from that business may exist now or in the future.

(2) All title insurance companies, prepaid health care delivery plans, nonprofit service plans, and all fraternal benefit societies and beneficial societies subject to the Louisiana Insurance Code.

(3) Any other specialty type insurer not covered by the general law which shall be subject to this Part.

(4) Agents, brokers, or insurers, or any person or persons acting as an agent, broker, or a managing general agent of an insurer, any reinsurer, any holding company owning an insurer or any captive premium finance company, or any related entity, whether or not such persons are licensed to do an insurance business in this state.

Acts 1992, No. 1095, §2.

§732.2. Definitions

For the purposes of this Part:

(1) "Doing business" shall include any of the following, whether effected by mail or otherwise:

(a) The issuance or delivery of contracts of insurance to persons residing in this state.

(b) The solicitation of applications for such contracts, or other negotiations preliminary to the execution of such contracts.

(c) The collection of premiums, membership fees, assessments, or other considerations for such contracts.

(d) The transaction of matters subsequent to execution of such contracts and arising out of them.

(e) Operating under a license or certificate of authority, as an insurer, issued by the Department of Insurance.

(f) Acting as an agent, broker, or managing agent of an insurer, acting as a reinsurer, or the ownership of an insurer by a holding company, or the operation of a captive premium finance company, or related entity.

(2)(a) "Fair consideration" is given for property or obligation when:

(i) In exchange for such property or obligation, as a fair equivalent therefor, and in good faith, property is conveyed or services are rendered or an obligation is incurred or an antecedent debt is satisfied.

(ii) Such property or obligation is received in good faith to secure a present advance or antecedent debt in an amount not disproportionately small as compared to the value of the property or obligation obtained.

(b) Any transfer within six months prior to the institution of delinquency proceedings shall be presumed not to have been for fair consideration, and the burden of proving fair consideration shall be on the party alleging it to have been given.

(3)(a) "Insolvency" or "insolvent" shall mean:

(i) For an insurer issuing only assessable fire insurance policies:

(aa) The inability to pay any obligation within thirty days after it becomes payable.

(bb) If an assessment be made within thirty days after such date, the inability to pay such obligation thirty days following the date specified in the first assessment notice issued after the date of loss as provided by law.

(ii) For any other insurer, the inability to pay its obligations when they are due, or a condition when its admitted assets do not exceed its liabilities plus the greater of:

(aa) Any capital and surplus required by law for its organization.

(bb) The total par or stated value of its authorized and issued capital stock.

(b) As to any insurer licensed to do business in this state as of the effective date of this Part* which does not meet the standard established under Item (ii) of this Subparagraph, the term "insolvency" or "insolvent" shall mean, for a period not to exceed three years from the effective date of this Part,* that it is unable to pay its obligations when they are due or that its admitted assets do not exceed its liabilities plus any required capital contribution ordered by the commissioner under provisions of the insurance law.

(c) For purposes of this Paragraph, "liabilities" shall include but not be limited to reserves required by statute, by general regulations of the Department of Insurance or by specific requirements imposed by the commissioner upon a subject company at the time of admission or subsequent thereto.

(4) "Insurer" shall mean any person who has done, purports to do, is doing, or is licensed to do an insurance business, and is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization, administrative supervision, or conservation by, any commissioner of insurance, or the equivalent insurance supervisory official of another state. For purposes of this Part, any other persons included under R.S. 22:732.1 shall be deemed to be insurers. "Insurers' net estate" shall mean that portion of the insurer's assets which remain after liquidation and are available for distribution under this Part.

(5) "Transfer" shall mean and include the sale and transfer and every other and different mode, direct or indirect, of disposing of or of parting with property or with an interest therein, or with the possession thereof or of fixing a lien upon property or upon an interest therein, absolutely or conditionally, voluntarily, by or without judicial proceedings. The retention of a security title to property delivered to a debtor shall be deemed a transfer suffered by the debtor.

Acts 1992, No. 1095, §2.

*As appears in Acts 1992, No. 1095, §2, eff. August 21, 1992.

§732.3. Venue

A. An action under this Part brought by the commissioner of insurance, in that capacity, or as conservator, rehabilitator, or liquidator may be brought in the Nineteenth Judicial District Court for the parish of East Baton Rouge or any court where venue is proper under any other provision of law.

B. Any action under this Part may also be brought in the parish where at least twenty-five percent of the policyholders of the insurer reside.

C. If an action is filed in more than one venue, the court shall consolidate all such cases into one court where venue is proper.

Acts 1993, No. 955, §1; Acts 1997, No. 1298, §1.

§733. Grounds for rehabilitation

A. Whenever any domestic insurer:

(1) Has obligations or claims exceeding its assets, cannot pay its contracts in full, or is otherwise found by the commissioner of insurance to be insolvent; or

(2) Has refused to submit its books, papers, accounts, records or affairs to the reasonable inspection or examination of the commissioner of insurance, or his actuaries, supervisors, deputies, or examiners; or

(3) Has neglected or refused to observe an order of the commissioner of insurance to make good within the time prescribed by law any deficiency, whenever its capital, if a stock insurer, or its required surplus, if an insurer other than stock, shall have become impaired; or

(4) Has, by articles of consolidation, contract or reinsurance or otherwise, transferred or attempted to transfer its entire property or business not in conformity with this Code, or entered into any transaction the effect of which is to merge substantially its entire property or business in any other insurer without having first obtained the written approval of the commissioner of insurance pursuant to the provisions of this Code; or

(5) Is found to be in such condition that its further transaction of business would be hazardous to its policyholders, or to its creditors, or to the public; or

(6) Has an officer who has refused upon reasonable demand to be examined under oath touching its affairs; or

(7) Is found to be in such condition that it could not meet the requirements for organization and authorization as required by law, except as to the amount of the surplus required of a stock insurer in R.S. 22:71, and except as to the amount of the surplus required by this Code to be maintained; or

(8) Has ceased for the period of one year to transact insurance business; or

(9) Has commenced, or has attempted to commence, any voluntary liquidation or dissolution proceedings, or any proceeding to procure the appointment of a receiver, liquidator, rehabilitator, sequestrator, or similar officer for itself; or

(10) If a party, either plaintiff or defendant in any proceeding in which an application is made for the appointment of a receiver, custodian, liquidator, rehabilitator, sequestrator or similar officer, for such insurer or its property, or a receiver, custodian, liquidator, rehabilitator, sequestrator or similar officer, for such insurer or its property is appointed by any court, or such appointment is imminent; or

(11) Consents to such an order by a majority of its directors, stockholders or members; or

(12) Has not organized and obtained a certificate authorizing it to commence the transaction of its business within the period of time prescribed by the sections of this Code under which it is or proposes to be organized; or

(13) Gives reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer; or

(14) Within the previous four years, the insurer has willfully violated its charter or articles of incorporation, its bylaws, any insurance law of this state, or any valid order of the commissioner, or failed to maintain adequate records in accordance with statutory accounting practices and generally accepted accounting principles; or

(15) Has failed to file its annual report or other financial report required by R.S. 22:1451 within the time allowed by law and, within ten days of receipt of written demand by the commissioner, has failed to provide the report; or

(16) Has failed to pay a final judgment rendered against it in any state upon any insurance contract issued or assumed by it, within sixty days after the judgment became final or within sixty days after time for taking an appeal has expired, or within sixty days after dismissal of an appeal before final determination whichever date is the later; then

B. The commissioner of insurance may apply by petition to the district court of the parish in which said insurer has its principal office, or to the district court of the parish of East Baton Rouge, or to any one of the judges thereof should the court be in vacation, at the commissioner of insurance's sole option, for a rule to show cause why an order to rehabilitate, conserve, liquidate, or dissolve such insurer as provided in this Part should not be entered, and for such other relief as the nature of the case and the interest of the insurer's policyholders, members, stockholders, creditors, or the public may require.

Acts 1958, No. 125; Acts 1992, No. 808, §1, eff. July 7, 1992; Acts 1992, No. 1095, §2; Acts 1993, No. 955, §1.

§734. Injunction

The court shall have jurisdiction over matters brought by or against the Department of Insurance or the commissioner of insurance, at any time after the filing of the petition, to issue an injunction restraining such insurer and its officers, agents, directors, employees, and all other persons from transacting any insurance business or disposing of its property until the further order of the court. The court may issue such other injunctions or enter such other orders as may be deemed necessary to prevent interference with the proceedings, or with the commissioner of insurance's possession and control or title, rights, or interests as herein provided or to prevent interference with the conduct of the business by the commissioner of insurance, and may issue such other injunctions or enter such other orders as may be deemed necessary to prevent waste of assets or the obtaining of preferences, judgments, attachments, or other like liens or the making of any levy against such insurer or its property and assets while in the possession and control of the commissioner of insurance.

Acts 1958, No. 125; Acts 1992, No. 808, §1, eff. July 7, 1992; Acts 1993, No. 955, §1.

§734.1. Cooperation of officers, owners, and employees; civil and criminal penalties

A. Any officer, manager, director, trustee, owner, employee, or agent of any insurer, or any other persons with authority over or in charge of any segment of the insurer's affairs, shall cooperate with the commissioner in any proceeding under this Part or any investigation preliminary to the proceeding.

B. No person shall obstruct or interfere with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto.

C. No person shall provide to the commissioner statements, documents, or records, which are fraudulent or materially false.

D. The court having jurisdiction over a proceeding under this Part shall have the authority to issue such orders, including injunctive relief, as appropriate, for the enforcement of this Section.

E. Failure to comply with such court order shall subject the violator to incarceration for civil contempt until compliance with the order has been obtained, and a fine not to exceed one hundred thousand dollars, or both.

F. Whosoever shall knowingly and intentionally violate any provisions of this Section shall be guilty of a felony. For each violation of which such person is convicted, the offender shall be punished by imprisonment at hard labor for not more than five years, or a fine not to exceed one hundred thousand dollars, or both.

Acts 1992, No. 1095, §2.

§735. Order of rehabilitation or liquidation

A. On the return of such order to show cause and after a full hearing, which shall be held by the court without delay, the court shall enter an order either dismissing the petition or finding that sufficient cause exists for rehabilitation or liquidation and directing the commissioner of insurance to take possession of the property, business, and affairs of such insurer and to rehabilitate or liquidate the same as the case may be. The commissioner of insurance shall be responsible on his official bond for all assets coming into his possession. The commissioner of insurance and his successor and successors in office shall be vested by operation of law with the title to all property, contracts, and rights of action of the insurer as of the date of the order directing rehabilitation or liquidation.

B. Notwithstanding any law to the contrary, the filing of a suit by the commissioner of insurance seeking an order of conservation or rehabilitation shall suspend the running of prescription as to all claims in favor of the subject insurer during the pendency of such proceeding. The filing of a suit by the commissioner of insurance seeking an order of liquidation shall interrupt the running of prescription as to such claims from the date of the filing of such proceeding for a period of two years, if an order of liquidation is granted.

C. When an order of rehabilitation is issued by the court, on joint motion by the receiver and the Louisiana Insurance Guaranty Association, the order may contain a provision allowing for the payment of claims by the Louisiana Insurance Guaranty Association as specified by the receiver in a subsequent motion for payment, prior to an order of liquidation. Notwithstanding any other provision of law to the contrary, nothing contained within this Code or other provision of Louisiana law shall prohibit or deter any other insurer which is not in rehabilitation, from payment or settlement of claims brought against such insurer or its insured.

Acts 1958, No. 125; Acts 1993, No. 955, §1.

§736. Duties of commissioner of insurance as rehabilitator; termination

A. Upon the entry of an order directing rehabilitation, the commissioner of insurance shall immediately proceed to conduct the business of the insurer and take such steps towards removal of the causes and conditions which have made such proceedings necessary as may be expedient. B. If at any time the commissioner of insurance shall find that it is to the best interests of policyholders, creditors and the insurer to effect a plan of mutualization or rehabilitation, he may submit such plan to the court for its approval. Such plan, in addition to any other terms and provisions as may, by the commissioner of insurance be deemed necessary or advisable, may include a provision imposing liens upon the net equities of policyholders of the insurer, and in the case of life insurers, a provision imposing a moratorium upon the loan or cash surrender values of the policies, for such period and to such an extent as may be necessary. Notice of the hearing upon any such plan shall be given in the manner as may be fixed by the court and upon such hearing the court may either approve or disapprove the plan or modify it in such manner and to such extent as to the court shall seem appropriate.

C. If at any time the commissioner of insurance shall find that further efforts to rehabilitate the insurer would be futile and would result in loss to the creditors, policyholders, stockholders or any other persons interested, he may apply to the court in the same proceeding for an order directing the liquidation of the property, business and affairs of such insurer.

D. If at any time the commissioner of insurance shall find that the causes and conditions which made such proceeding necessary have been removed he may petition the court for an order terminating the conduct of the business by said commissioner of insurance and permitting such insurer to resume possession of its property and the conduct of its business and for a full discharge of all liability and responsibility of such commissioner of insurance. No order for the return to such insurer of its property and business shall be granted unless the court after a full hearing shall determine that the purposes of the proceeding have been fully accomplished.

E. The rehabilitator, in addition to other powers, shall have the following powers:

(1) To avoid fraudulent transfers.

(2) To audit the books and records of all agents of the insurer insofar as those records relate to the business activities of the insurer.

(3) To use assets of the estate of an insurer under a liquidation order to transfer policy obligations to a solvent assuming insurer.

(4) To enter into such agreements or contracts as are necessary to carry out the full or partial plan for rehabilitation or the order to liquidate and to affirm or disavow any contracts to which the insurer is a party.

(5) To authorize and issue additional shares of stock in the insurer, of any class, and upon such terms and conditions as the court may approve.

F. In addition to any other duty under this Section, the commissioner shall estimate, based upon available information, the total amount of expenditures and obligations to be incurred by the Department of Insurance, in connection with any rehabilitation or liquidation under this Section and determine if this is the most cost-effective to the department and to any insurance guaranty association established under the provisions of this Title. The commissioner shall periodically update these estimates.

Acts 1958, No. 125; Acts 1992, No. 1095, §2.

§737. Duties of commissioner of insurance as liquidator; sales; notice to creditors; reinsurance

A. Upon the entry of an order directing liquidation, the commissioner of insurance shall immediately proceed to liquidate the property, business and affairs of the insurer. He is hereby authorized to deal with the property and business of the insurer in his name as commissioner of insurance, or, if the court shall so order, in the name of the insurer.

B. He may, subject to the approval of the court, sell or otherwise dispose of the real and personal property, or any part thereof, and sell or compromise all doubtful or uncollectible debts or claims owing to or by the insurer including claims based upon an assessment levied against a member or a subscriber of any insurer issuing assessable policies, and including contingent claims allowable under this Part.

C. He shall as soon as may be conveniently possible, give notice to all creditors who may have claims against the insurer, as revealed by the records of the insurer, to present the same.

D. In order to preserve so far as possible the right and interest of the policyholders of the insurer whose contracts were cancelled by the liquidation order and of such other creditors as may be possible, the commissioner of insurance may solicit a contract or contracts whereby a solvent insurer or insurers will agree to assume in whole, or in part, or upon a modified basis, the liabilities owing to said former policyholders or creditors. If, after a full hearing upon a petition filed by the commissioner of insurance, the court shall find that the commissioner of insurance endeavored to obtain the best contract for the benefit of said parties in interest, and if the said commissioner of insurance shall report to the court that he is ready and willing to enter into a contract and submit a copy thereof to the court, the court shall examine the procedure and acts of the commissioner of insurance, and if the court shall find that the best possible contract in the interests of said parties has been obtained and that it is best for the interests of said parties that said contract be entered into, the court shall by written order approve the acts of the commissioner of insurance and authorize him to execute said contract.

E. The commissioner shall not designate nor a court of competent jurisdiction appoint an auditor or investigator who has previously audited or investigated the liquidated insurer.

Acts 1958, No. 125. Amended by Acts 1960, No. 171, §1; Acts 1991, No. 742, §1.

§737.1. Premiums due; effect of injunction, or order of rehabilitation or liquidation

A. If an insurer is enjoined from transacting any insurance business or from disposing of its property under R.S. 22:734 or issued an order directing rehabilitation or liquidation under R.S. 22:735, any premium due or payable on a contract of insurance which was issued by the insurer shall be paid by the insured as provided in this Section.

B. When an insurer is enjoined from transacting insurance business or from disposing of its property under R.S. 22:734, any and all premiums due the insurer shall be paid to the commissioner of insurance until dissolution or modification of the injunction.

C. When an order directing rehabilitation is issued under R.S. 22:735, any and all premiums due the insurer shall be paid to the commissioner of insurance until termination, under the provisions of R.S. 22:735, of the order directing rehabilitation.

D. All contracts of insurance issued by the insurer are cancelled upon issuance of an order, under the provisions of R.S. 22:735, directing liquidation, and no premium shall be due or payable to the insurer. Such contracts formerly issued by the insurer may be assumed in whole or in part, or upon a modified basis, by a solvent insurer or insurers if approved under the provisions of R.S. 22:737(D).

E. Upon issuance of an injunction under R.S. 22:734 or an order of rehabilitation or liquidation under R.S. 22:735, the commissioner of insurance shall notify every holder of a contract of insurance issued by the insurer of such injunction or order and that payment of premiums shall be made under the provisions of this Section. Such notice shall be mailed to each such policyholder by letter with proof of mailing within ten days after issuance of the injunction or court order of rehabilitation or liquidation.

Acts 1989, No. 697, §1; Acts 1992, No. 1095, §1.

§737.2. Unearned premium; limitation of claims by insolvent insurers

A. Any claim of an insolvent insurer against an insured or against the agent through whom a policy was written concerning any policy of insurance issued or delivered in this state shall be subject to the following limitations:

(1) The insured shall not be liable to an insolvent insurer for any premium which had not been earned on a pro rata basis on the date the insurer was declared insolvent by a court of competent jurisdiction.

(2) The insured shall be entitled to credit against any obligation owed to the insolvent insurer for any unearned premium which the insured has paid and for which he has not been reimbursed by the Louisiana Insurance Guaranty Association or the Louisiana Life and Health Insurance Guaranty Association.

(3) The agent, through whom the policy was written, shall not be liable to the insolvent insurer for any premiums which had not been earned on a pro rata basis on the date the insurer was declared insolvent. The agent is entitled to retain the commission due on earned premiums. The insured is entitled to any unearned premium which the agent has collected but has not remitted to the insurer.

B. In this Section, the term "insolvent insurer" includes any insurer who has been declared to be insolvent under the laws of any state and its liquidator, rehabilitator, receiver, statutory successor, or other legal representative.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

§738. Rights and liabilities of creditors fixed upon liquidation

A. The rights and liabilities of the insurer and of its creditors, except those holding contingent claims, and of its policyholders, stockholders, or members and of all other persons interested in its assets shall, unless otherwise ordered by the court, be fixed as of the date of the entry of the order directing liquidation. The rights of claimants holding contingent claims on said date shall be determined as hereinafter provided.

B. All executory contracts of an insurer, other than contracts under which such insurer has an established benefit without any additional expenditure, shall be cancelled as of the date of the entry of an order of liquidation unless the court provides otherwise in the liquidation order, provided that the commissioner may petition the court within sixty days of the entry of such order to reaffirm any such contract. Any contract that is reaffirmed shall remain in force in accordance with the court's order and any obligation of the insurer under such contract shall become an administrative expense of the liquidation unless otherwise ordered by the court.

Acts 1958, No. 125; Acts 1993, No. 955, §1.

§739. Deposit of monies collected

The monies collected by the commissioner of insurance in a proceeding under this Part shall be, from time to time, deposited in one or more state or national banks, savings banks, trust companies, or savings and loan associations chartered to do business in this state. Any depository so selected shall provide the same security for such deposits as that required for the deposit of state funds pursuant to the provisions of R.S. 49:321. The commissioner of insurance may in his discretion deposit such monies or any part thereof in a national bank or trust company as a trust fund. For the purposes of this Section, the commissioner of insurance shall be considered a "depositing authority" pursuant to R.S. 49:321.

Acts 1958, No. 125; Amended by Acts 1982, No. 748, §1; Acts 1991, No. 738, §1.

§739.1. Investment in securities

Notwithstanding any law to the contrary, the commissioner of insurance may invest any monies held in any proceedings under this Part in the following securities:

(1) Investments in or loans upon the security of general obligations of the government of the United States or of the state.

(2) To the full extent of the amount insured or capable of being securitized or guaranteed in:

(a) Bonds or notes secured by a mortgage or trust deed issued, assumed, guaranteed, or insured by the United States or by any agency of the United States.

(b) Securities issued or mortgages guaranteed by the Federal National Mortgage Association or other similar corporations regulated by an agency of the United States.

(c) Conventional first mortgage loans capable of being securitized into guaranteed Federal National Mortgage Association mortgage backed securities.

(d) Bonds issued, assured, and guaranteed by the Inter-American Development Bank or the African Development Bank.

(e) First mortgage loans guaranteed by the administrator of veteran affairs pursuant to the provisions of the Servicemen's Readjustment Act of 1944, as amended.

Acts 1992, No. 783, §1.

§740. Borrowing on the pledge of assets

For the purpose of facilitating the rehabilitation, liquidation, conservation or dissolution provided for by this Part the commissioner of insurance may, subject to the approval of the court, borrow money and execute, acknowledge and deliver certificates of indebtedness upon such terms and entitled to such liens and priorities as may be fixed by the court, or notes or other evidence of indebtedness therefor and secure the repayment of the same by the mortgage, pledge, assignment, transfer in trust or hypothecation of any or all of the property whether real, personal or mixed of the insurer against which a proceeding has been brought under this Part. Subject to the approval of the court, he shall also have power to take any and all other action necessary and proper to consummate any such loans and to provide for the repayment thereof. The commissioner of insurance shall incur no personal liability by virtue of any loan made pursuant to this Section.

Acts 1958, No. 125.

§741. Order of dissolution

A. If the insurer against whom the petition for liquidation is filed be a corporation and the petition prays for dissolution of such insurer, the court shall have jurisdiction either before or after final liquidation of the property, business, and affairs of such insurer, after citation of an order to show cause as aforesaid and a full hearing, to enter a decree dissolving such insurer. The court may likewise, regardless of whether an order of liquidation is sought or has been obtained, upon proper petition by the commissioner of insurance, order dissolution of an insurer when it has failed to qualify for a certificate of authority authorizing it to commence the transaction of its business, or when an insurer has no assets and no means for payment of liabilities. In any such decree of dissolution, the court, may, upon satisfactory demonstration that all of the assets of the insurer shall be applied to payment of liabilities of the insurer in the manner and priority as provided by law, and after such notice and hearing as the court shall require, issue an order discharging the insurer of all unsatisfied liabilities.

B. Notwithstanding any provision of Subsection A of this Section, upon application by the commissioner and following notice as prescribed by the court and a hearing, the court may authorize the commissioner of insurance to sell the corporation as an entity, together with any of its licenses to do business, despite the entry of an order of liquidation. The sale may be made on terms and conditions the court deems appropriate including but not limited to the distribution of the proceeds of the sale of the corporate entity and licenses for the benefit of policyholders and creditors in the manner set forth in R.S. 22:746. The legal existence of a legal entity that is placed under an order of rehabilitation, liquidation, or conservation shall be terminated only if the court orders its dissolution as a legal entity, as provided herein.

Acts 1958, No. 125; Acts 1989, No. 446, §1, eff. Sept. 1, 1989; Acts 1993, No. 955, §1.

§742. Only commissioner of insurance may apply for appointment of receiver or liquidator

No order, judgment, or decree enjoining, restraining, or interfering with the prosecution of the business of any insurer or for the appointment of a temporary or permanent receiver, rehabilitator, or liquidator of a domestic insurer, or receiver or conservator of a foreign or alien insurer, shall be made or granted otherwise than upon the petition of the commissioner of insurance as provided in this Part, except in an action by a judgment creditor, or in proceedings supplementary to execution after notice that a final judgment has been entered and that the judgment creditor intends to file a complaint praying for any of the relief mentioned in this Section, has been served upon the commissioner of insurance at least thirty days prior to the filing of such petition.

Acts 1958, No. 125; Acts 1992, No. 808, §1, eff. July 7, 1992; Acts 1993, No. 955, §1.

§743. Appointment of assistants

A. For the purpose of this Part, and in connection with proceedings involving only domestic insurers, the commissioner of insurance shall have the power to appoint one or more special deputies as his agent or agents and to employ such clerks, or assistants as may by him be deemed necessary, and to give each of such persons such powers to assist him as he may consider wise. The compensation of every such special deputy, agent, clerk, or assistant shall be fixed, and all expenses of taking possession of the property of the insurer and the administration thereof shall be approved, by the commissioner of insurance, all subject to the approval of the court, and shall be paid out of the funds or assets of the insurer.

B. The attorney general shall provide representation for the commissioner of insurance in all matters covered under this Part. The attorney general may, in cases in which he deems it appropriate, appoint special counsel to provide this representation. The attorney general shall submit his certification of expenses and legal fees, both for staff and outside counsel, to the court for approval. Upon approval by the court, these amounts shall be paid out of the funds or assets of the insurer.

C. Attorneys employed by the attorney general for purposes of this Section shall be named by the commissioner of insurance, with the approval of the attorney general, and shall perform their duties under the supervision of the attorney general.

Acts 1958, No. 125. Amended by Acts 1979, No. 116, §1, eff. June 29, 1979; Acts 1991, No. 382, §1, eff. July 6, 1991.

§744. Exemption from filing fees

The commissioner of insurance shall not be required to pay any fee to any public officer for filing, recording or in any manner authenticating any paper or instrument relating to any proceeding under this Part, nor for services rendered by any public officer for serving any process; but such fees and costs may be taxed as costs against the defendant in the suit by order of the court and paid to such public officer.

Acts 1958, No. 125.

§745. Prohibited and voidable transfer and liens

A. No insurer shall make any transfer of or create any lien upon any of its property with the intent of giving to or enabling any creditor or policyholder to obtain a greater percentage of this debt than any other creditor of the same class.

B. Any transfer of, or lien upon, any property of any insurer made or created within four months prior to the filing of a petition for an order to show cause under this Part, which gives to any creditor or policyholder or enables him to obtain a greater percentage of his debt than any other creditor or policyholder in the same class, which is accepted by a creditor or policyholder having reasonable cause to believe that such a preference will occur, shall be voidable. Where the preference consists in a transfer, such period of four months shall not expire until four months after the date of the recording or registering of the transfer if by law such recording or registering is required.

C. Every director, officer, employee, stockholder, member, or any other person, acting on behalf of such insurer, who, within two years prior to the filing of a petition for an order to show cause against such insurer under this Part, shall knowingly participate in the making of any transfer or the creation of any lien prohibited by Sub-section A and every person receiving any property of, or cash surrender from, such insurer or the benefit thereof, as a result of a transaction voidable under Sub-section B, shall be jointly and severally liable therefor and shall be bound to account to the commissioner of insurance as rehabilitator, liquidator or conservator as the case may be.

D. The commissioner of insurance as rehabilitator, liquidator, or conservator may avoid any transfer of or lien upon the property of an insurer which any creditor, stockholder or member of such insurer might have avoided and may recover the property so transferred or its value from the person to whom it was transferred unless he was a bona fide holder for value prior to the date of the entry of the order of liquidation. Such property may be recovered or its value collected from whoever may have received it except a bona fide holder for value.

Acts 1958, No. 125.

§745.1. Fraudulent transfers prior to petition

A. Every transfer made or suffered and every obligation incurred by an insurer within one year prior to the filing of a successful petition for rehabilitation or liquidation under this Part is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay, or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under this Part, which is fraudulent under this Section, may be avoided by the receiver, except as to a person who in good faith is a purchaser, lienor, or obligee for a present fair equivalent value, and except that any purchaser, lienor, or obligee, who in good faith has given consideration less than fair for such transfer, lien, or obligation, may retain the property, lien, or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event, the receiver shall succeed to and may enforce the rights of the purchaser, lienor, or obligee.

B.(1) A transfer of property other than immovable property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal proceedings on a simple contract could become superior to the rights of the transferee under R.S. 22:745.3(C).

(2) A transfer of immovable property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(3) A transfer which creates a statutory lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(4) Any transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(5) The provisions of this Subsection apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

C. Any transaction of the insurer with a reinsurer shall be deemed fraudulent and may be avoided by the receiver under Subsection A of this Section if both of the following occur:

(1) The transaction consists of the termination, adjustment, or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transactions, unless the reinsurer gives a present fair equivalent value for the release.

(2) Any part of the transaction took place within one year prior to the date of filing of the petition through which the receivership was commenced.

D. Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under Subsection A of this Section shall be personally liable therefor and shall be bound to account to the liquidator.

Acts 1992, No. 1095, §2; Acts 1993, No. 955, §1.

§745.2. Fraudulent transfer after petition

A. After a petition for rehabilitation has been filed, a transfer of any of the immovable property of the insurer made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value; or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred. The commencement of a proceeding in rehabilitation or liquidation shall be constructive notice upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the recorder of mortgages in the parish where any immovable property in question is located. The exercise by a court of the United States or any state or jurisdiction to authorize or effect a judicial sale of immovable property of the insurer within any parish in any state shall not be impaired by the pendency of such a proceeding unless the copy is recorded in the parish prior to the consummation of the judicial sale.

B. After a petition for rehabilitation or liquidation has been filed and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted:

(1) A transfer of any of the property of the insurer, other than immovable property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value; or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred.

(2) A person indebted to the insurer or holding property of the insurer may, if acting in good faith, pay the indebtedness or deliver the property, or any part thereof, to the insurer or upon his order, with the same effect as if the petition were not pending.

(3) A person having actual knowledge of the pending rehabilitation or liquidation shall be presumed not to act in good faith.

(4) A person asserting the validity of a transfer under this Section shall have the burden of proof. Except as elsewhere provided in this Section, no transfer by or on behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator shall be valid against the liquidator.

C. Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under Subsection A of this Section shall be personally liable therefor and shall be bound to account to the liquidator.

D. Nothing in this Part shall impair the negotiability of currency or negotiable instruments.

Acts 1992, No. 1095, §2; Acts 1993, No. 955, §1.

§745.3. Voidable preferences and liens

A.(1) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one year before the filing of a successful petition for liquidation under this Part, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then such a transfer shall be deemed a preference if made or suffered within one year before the filing of the successful petition for liquidation, or within two years before the filing of the successful petition for liquidation, whichever time is shorter.

(2) Any preference may be avoided by the liquidator if:

(a) The insurer was insolvent at the time of the transfer.

(b) The transfer was made within four months before the filing of the petition.

(c) The creditor receiving it or to be benefitted thereby or his agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent.

(d) The creditor receiving it was an officer, or any employee, attorney, or other person who was in fact in a position of comparable influence in the insurer to an officer whether or not he held such position, or any shareholder holding, directly or indirectly, more than five percent of any class of any equity security issued by the insurer, or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

(3) When the preference is voidable, the liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property; except when a bona fide purchaser or lienor has given less than fair equivalent value, he shall have a lien upon the property to the extent of the consideration actually given by him. When a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

B.(1) A transfer of property other than immovable property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

(2) A transfer of property other than immovable property shall be deemed to be made or suffered when it becomes so perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

C.(1) A lien obtainable by legal proceedings upon a simple contract is one arising in the ordinary course of such proceedings upon the entry or docketing of a judgment or decree, or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy. It does not include liens which under applicable law are given a special priority over other liens which are prior in time.

(2) A lien obtainable by legal proceedings could become superior to the rights of a transferee, or a purchaser could obtain rights superior to the rights of a transferee within the meaning of Subsection B of this Section, if such consequences would follow only from the lien or purchase itself, or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser, with or without the aid of ministerial action by public officials. Such a lien could not, however, become superior and such a purchase could not create superior rights for the purpose of Subsection B through any acts subsequent to the obtaining of such a lien or subsequent to such a purchase which require the agreement or concurrence of any third party or which require any further judicial action or ruling.

D. A transfer of property for or on account of a new and contemporaneous consideration which is deemed under Subsection B of this Section to be made or suffered after the transfer because of delay in perfecting it does not thereby become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchasers' rights are performed within twenty-one days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if such a loan is actually made, or a transfer which becomes security for a future loan shall have the same effect as a transfer for or on account of a new and contemporaneous consideration.

E. If any lien deemed voidable under R.S. 22:745.3(A)(2) has been dissolved by the furnishing of a bond or other obligation, the surety on which has been indemnified, directly or indirectly, by the transfer of or the creation of a lien upon any property of an insurer before the filing of a petition under this Part which results in a liquidation order, the indemnifying transfer or lien shall also be deemed voidable.

F. The property affected by any lien deemed voidable under Subsections A and E of this Section shall be discharged from such lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety shall pass to the liquidator, except that the court may on due notice order any such lien to be preserved for the benefit of the estate and the court may direct that such conveyance be executed as may be proper or adequate to evidence the title of the liquidator.

G. The Nineteenth Judicial District Court for the Parish of East Baton Rouge may conduct by summary proceeding any proceeding by the liquidator to hear and determine the rights of any parties under this Section. Reasonable notice of any hearing in the proceeding shall be given to all parties in interest, including the obligee of a releasing bond or other like obligation. When an order is entered for the recovery of indemnifying property in-kind or for the avoidance of an indemnifying lien, the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien. If the value is less than the amount for which the property is indemnified or than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment of its value, as ascertained by the court, to the liquidator, within such reasonable times as the court shall fix.

H. The liability of the surety under a releasing bond or other like obligation shall be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and avoided by the liquidator, or where the property is retained under Subsection G of this Section to the extent of the amount paid to the liquidator.

I. If a creditor has been preferred, and afterward in good faith gives the insurer further credit without security of any kind, for property which becomes a part of the insurer's estate, the amount of the new credit remaining unpaid at the time of the petition may be set off against the preference which would otherwise be recoverable from him.

J. If an insurer shall, directly or indirectly, within four months before the filing of a successful petition for liquidation under this Part, or at any time in contemplation of a proceeding to liquidate it, pay money or transfer property to an attorney at law for services rendered or to be rendered, the transactions may be examined by the court on its own motion or shall be examined by the court on petition of the liquidator and shall be held valid only to the extent of a reasonable amount to be determined by the court, and the excess may be recovered by the liquidator for the benefits of the estate. However, when the attorney is in a position of comparable influence in the insurer or an affiliate thereof, payment of any money or the transfer of any property to the attorney at law for services rendered or to be rendered shall be governed by the provision of R.S. 22:745.3(A)(2)(d).

K.(1) Every officer, manager, employee, shareholder, member, subscriber, attorney, or any other person acting on behalf of the insurer who knowingly participates in giving any preference when he has reasonable cause to believe the insurer is about to become insolvent at the time of the preference shall be personally liable to the liquidator for the amount of the preference. It is permissible to infer that there is a reasonable cause to so believe if the transfer was made within four months before the date of filing of the successful petition for liquidation.

(2) Every person receiving any property from the insurer or the benefit thereof as a preference voidable under Subsection A of this Section shall be personally liable therefor and shall be bound to account to the liquidator.

(3) Nothing in this Subsection shall prejudice any other claim by the liquidator against any person.

Acts 1992, No. 1095, §2; Acts 1993, No. 955, §1.

§745.4. Claims of holders of void or voidable rights

A. No claim of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment, or encumbrance voidable under this Part shall be allowed unless he surrenders the preference, lien, conveyance, transfer, assignment, or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the liquidator within thirty days from the date of the entering of the final judgment, except that the court having jurisdiction over the liquidation may allow further time if there is an appeal or other continuation of the proceeding.

B. A claim allowable under Subsection A of this Section by reason of the avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, or transfer may be filed as an excused last filing if filed within thirty days from the date of the avoidance, or within the further time allowed by the court under Subsection A of this Section.

Acts 1992, No. 1095, §2.

§746. Priority of claims

The priorities of distribution of general assets from the insurer's estate shall be as follows:

(1) The commissioner's costs and expenses of administration and the claims handling expenses of the Insurance Guaranty Association, the Louisiana Life and Health Insurance Guaranty Association, and any similar organization in another state, as provided for in R.S. 22:1385(B) and 1395.13(D)(2).

(2) Claims by policyholders, beneficiaries, and insureds arising from and within the coverage of and not in excess of the applicable limits of insurance policies and insurance contracts issued by the insurer; and liability claims against insureds which claims are within the coverage of and not in excess of the applicable limits of insurance policies and insurance contracts issued by the insurer; and claims of the Insurance Guaranty Association, the Louisiana Life and Health Insurance Guaranty Association, and any similar organization in another state, as provided for in R.S. 22:1385(B), 1379(3), 1395.3, and 1395.13(D)(2).

(3) Claims of the federal government other than those claims in Paragraph (2) of this Section.

(4) Compensation actually owing to employees other than officers of an insurer, for services rendered within three months prior to the commencement of a proceeding against the insurer under this Part, but not exceeding two thousand five hundred dollars for such employee, shall be paid prior to the payment of any other debt or claim and in the discretion of the commissioner of insurance may be paid as soon as practicable after the proceeding has commenced; except, that at all times the commissioner of insurance shall reserve such funds as will in his opinion be sufficient for the payment of all claims in Paragraphs (1), (2), and (3). This priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of such employees.

(5) Claims under nonassessable policies for unearned premiums or other premium refunds and claims of general creditors, including claims of ceding and assuming companies in their capacity as such.

(6) All other claims.

Acts 1958, No. 125. Amended by Acts 1981, No. 412, §1; Acts 1995, No. 1210, §1, eff. June 29, 1995.

§747. Set-offs

In all cases of mutual debts or mutual credits between the insurer and another person, such credits and debts shall be set-off and the balance only shall be allowed or paid, provided, however, that no set-off shall be allowed in favor of any person where:

(1) The obligation of the insurer to such person was purchased by or transferred to such person with a view of its being used as a set-off, or

(2) The obligation of such person is to pay an assessment levied against the members or subscribers of any insurer which issued assessable policies, or to pay a balance upon a subscription to the shares of a stock insurer.

(3) Where an agent, agency or other person purchases a policy of insurance for the unexpired term of the policy and takes an assignment of the unearned premium claim from the insured, this action shall not be considered as a purchase of an obligation with a view of its being used as a set-off.

Acts 1958, No. 125. Amended by Acts 1960, No. 172, §1.

§748. Time to file claims

A. If upon the granting of an order of liquidation under this Part or at any time thereafter during the liquidation proceeding, the insurer shall not be clearly solvent, the court shall after such notice and hearing as it deems proper, make an order declaring the insurer to be insolvent. Thereupon, regardless of any prior notice which may have been given to creditors, the commissioner of insurance shall notify all persons who may have claims against such insurer and who have not filed proper proofs thereof, to present the same to him, at a place specified in such notice, within four months from the date of the entry of such order, or, if the commissioner of insurance shall certify that it is necessary, within such longer time as the court shall prescribe. The last day for the filing of proofs of claims shall be specified in the notice. Such notice shall be given in a manner determined by the court.

B. Proofs of claim may be filed subsequent to the date specified, but, no such claim shall share in the distribution of the assets until all allowed claims, proofs of which have been filed before said date, have been paid in full with interest.

Acts 1958, No. 125.

§749. Proof and allowance of claims

A. A proof of claim shall consist of a statement under oath, in writing, signed by the claimant, setting forth the claim, the consideration therefor, and whether any, and if so, what securities are held therefor, and whether any, and if so, what payments have been made thereon, and that the sum claimed is justly owing from the insurer to the claimant. Whenever a claim is founded upon an instrument in writing, such instrument, unless lost or destroyed, shall be filed with the proof of claim. If such instrument is lost or destroyed, a statement of such fact and of the circumstances of such loss or destruction shall be filed under oath with the claim.

B. Upon the liquidation of any domestic insurer which has issued policies insuring the lives of persons, the commissioner of insurance shall, within a reasonable time, after the last day set for the filing of claims, make a list of the persons who have not filed proofs of claim with him and whose rights have not been reinsured, to whom it appears from the books of the insurer, there are owing amounts on such policies and he shall set opposite the name of each person such amount so owing to such person. The commissioner of insurance shall incur no personal liability by reason of any mistake in such list. Each person whose name shall appear upon said list shall be deemed to have duly filed prior to the last day set for filing of claims a proof of claim for the amount set opposite his name on said list.

C. No contingent claim other than claims of the character described in Sub-section D shall share in a distribution of the assets of an insurer which has been adjudicated to be insolvent by an order made pursuant to R.S. 22:748 except that a contingent claim, if properly presented, may be allowed, and entitled to share where such claim becomes absolute against the insurer on or before the last day fixed for the filing of proofs of claim against the assets of such insurer, or there is a surplus to be distributed as if no order pursuant to R.S. 22:748 had been made.

D.(1) When an insurer has been adjudicated to be insolvent by an order made pursuant to R.S. 22:748, any person who claims to have a cause of action against an assured of such insurer, which accrued prior to the filing of the petition for liquidation and which is the subject of indemnity under a liability policy issued by such insurer, or any assured against whom any such action is claimed to exist, may file a claim in the liquidation proceedings, regardless of the fact that such claim may be contingent, but no such claim shall be allowed in favor of an assured if any claim has been filed by the person who claims to have such cause of action against the assured. No such claim shall be allowed in favor of the assured, unless a final judgment shall be entered against the assured by a court of competent jurisdiction within three years from the filing of a petition to show cause against an insurer under this Part or within such further time as may be allowed by the court for good cause shown. In the event that the total amount of all allowable claims based upon causes of action arising out of the same act of any assured be greater than the total liability of the insurer in connection therewith, such claims shall be reduced pro rata and allowed in such sums so that the aggregate of such allowed claims shall equal such total liability.

(2) No judgment taken by default or collusion against the assured shall be considered as evidence in the liquidation proceeding either of the liability of such assured to the judgment creditor upon such cause of action or of the amount of damages to which such judgment creditor is entitled. No claim of such a judgment creditor, or any assured against whom such a judgment may have been taken, shall be allowed unless proof be made in the liquidation proceedings of the liability of such assured upon the alleged cause of action and the amount of damages arising therefrom.

(3) When the receiver allows or disallows a claim in a lesser amount than claimed, he shall notify the person making the claim by petition in the receivership proceedings, allowing ten days after receipt of said notice in which to file objections to the action of the receiver. The objections shall be heard in the receivership proceedings in a summary manner.

(4) No judgment or order against an insured or an insurer entered after the date of the commencement of proceedings under this Part shall be considered in the proceedings as evidence of liability or of the amount of damages of the insured or the insurer and no judgment or order entered at any time against an insured or the insurer by default or by collusion shall be considered as conclusive evidence in the proceedings under this Part, either of the liabilities of such insured or insurer to such person upon such cause of action or of the amount of damages to which such person is therein entitled. No claim of any judgment creditor or any insured against whom a judgment may have been taken shall be allowed unless proof is made in the proceedings under this Part of the liability of such insured upon the alleged cause of action and the amount of damages arising therein.

(5) Upon the issuance of an order appointing a receiver of a domestic insurer or of an alien insurer, no action at law or equity shall be brought against the insurer, its insureds, or the receiver, whether in this state or elsewhere, nor shall any such existing actions be maintained or further presented after issuance of such an order. Whenever, in the receiver's judgment, protection of the estate of the insurer necessitates intervention in an action against the insurer or its insured that is pending outside this state, the receiver may intervene in the action. The receiver may defend any action in which the receiver intervenes, at the election of and in the sole discretion of the receiver, under this Section at the expense of the estate of the insurer.

(6) When the receiver allows or disallows a claim in a lesser amount than claimed, he shall notify the person making the claim by petition in the receivership proceedings, allowing ten days after receipt of said notice in which to file objections to the action of the receiver. The objections shall be heard in the receivership by summary proceedings.

E. The value of securities held by secured creditors shall be determined by converting the same into money according to the terms of the agreement pursuant to which such securities were delivered to such creditors, or by such creditors and the commissioner of insurance by agreement, or by the court, and the amount of such value shall be credited upon the claims of such secured creditors and their claims allowed only for the balance.

F. Claims of creditors or policyholders who have received preferences voidable under R.S. 22:745 or to whom conveyances or transfers, assignments or encumbrances have been made or given which are void under R.S. 22:745, shall not be allowed unless such creditors or policyholders shall surrender such preferences, conveyances, transfers, assignments or encumbrances.

Acts 1958, No. 125. Amended by Acts 1960, No. 173, §1; Acts 1993, No. 955, §1.

§750. Report for assessment

Within three years from the date an order of rehabilitation or liquidation of a domestic mutual insurer or a domestic reciprocal insurer was filed in the office of the clerk of the court by which such order was made, the commissioner of insurance may make a report to the court setting forth:

(1) The reasonable value of the assets of the insurer;

(2) The insurer's probable liabilities; and

(3) The probable necessary assessments, if any, to pay all claims and expenses in full, including expenses of administration.

Acts 1958, No. 125.

§751. Levy of assessment

A. In the event of the entry of an order directing the commissioner of insurance to rehabilitate or liquidate any insurer which has issued assessable policies or contracts of insurance, the commissioner of insurance may, with leave of court, at any time during the pendency of the proceeding, levy such assessment or assessments against the members or subscribers of the insurer, as may be necessary to pay all allowed claims in full, to the same extent that such assessment or assessments might have been levied by the board of directors, attorney-in-fact or other governing body of the insurer. Such assessment or assessments shall become due and payable upon the levy thereof by the commissioner of insurance and shall cover the excess of the probable liabilities over the reasonable value of the assets, together with the cost of collection and probable percentage of uncollectibility thereof. The total of such assessments against any member or subscriber shall not exceed the maximum amount fixed in the contract of that member or subscriber.

B. No assessment shall be levied against any member or subscriber with respect to any non-assessable policy issued in accordance with this Code.

Acts 1958, No. 125.

§752. Order to pay assessment

After levy of assessment as provided in R.S. 22:751, upon the filing of a further detailed report by the commissioner of insurance, the court shall issue an order directing each member (if a mutual insurer), each subscriber (if a reciprocal insurer), or each underwriter (if a Lloyds insurer), if he shall not pay the amount assessed against him to the commissioner of insurance on or before a day to be specified in the order, to show cause why he should not be held liable to pay such assessment together with costs as set forth in R.S. 22:754 and why the commissioner of insurance should not have judgment therefor.

Acts 1958, No. 125.

§753. Publication and transmittal of assessment order

The commissioner of insurance shall cause a notice of such assessment order setting forth a brief summary of the contents of such order to be

(1) Published in such manner as shall be directed by the court; and

(2) Enclosed in a sealed envelope, addressed and mailed postage prepaid to each member or subscriber liable thereunder at his last known address as it appears on the records of the insurer, at least twenty days before the return day of the order to show cause provided for in R.S. 22:752.

Acts 1958, No. 125.

§754. Judgment upon the assessment

A. On the return day of the order to show cause provided for in R.S. 22:752 if the member or subscriber does not appear and serve verified objections upon the commissioner of insurance, the court shall make an order adjudging that such member or subscriber is liable for the amount of the assessment against him together with ten dollars cost, and that the commissioner of insurance may have judgment against the member or subscriber therefor.

B. If on such return day the member or subscriber shall appear and serve verified objections upon the commissioner of insurance there shall be a full hearing before the court or a referee to hear and determine, who, after such hearing, shall make an order either negativing the liability of the member or subscriber to pay the assessment or affirming his liability to pay the whole or some part thereof together with twenty-five dollars costs and the necessary disbursements incurred at such hearing, and directing that the commissioner of insurance in the latter case may have judgment therefor.

C. A judgment upon any such order shall have the same force and effect, and may be entered and docketed, and may be appealed from as if it were a judgment in an original action brought in the court in which the proceeding is pending.

Acts 1958, No. 125.

§755. Distribution of assets; priorities; unpaid dividends

A. Within one hundred twenty days of a final determination of insolvency of an insurer by a court of competent jurisdiction of this state, the commissioner of insurance shall make application to the court for approval of a proposal to disburse assets out of such insurer's marshalled assets from time to time as such assets become available, to the Insurance Guaranty Association and to any similar organization in another state.

B. Such a proposal shall at least include provisions for:

(1) Reserving amounts for the payment of the expenses of administration and claims falling within the priorities established in R.S. 22:746.

(2) Disbursement of the assets marshalled to date and subsequent disbursements of assets as they become available.

(3) Equitable allocation of disbursements to the Insurance Guaranty Association and each similar organization in another state entitled thereto.

(4) The securing by the commissioner of insurance from the Insurance Guaranty Association and each similar organization in another state entitled to disbursements pursuant to this Section of an agreement to return to the commissioner of insurance such assets previously disbursed as may be required to pay claims of secured creditors and claims falling within the priorities established in R.S. 22:746 in accordance with such priorities. No bond shall be required of the Insurance Guaranty Association or any similar organization in another state.

(5) A full report to be made by the Insurance Guaranty Association and any similar organization in another state receiving disbursements pursuant to this Section to the commissioner of insurance accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on such assets, and any other matter as the court may direct.

C. The proposal of the commissioner of insurance shall provide for disbursements to the Insurance Guaranty Association and any similar organization in another state in amounts at least equal to the payments made or to be made thereby for which the Insurance Guaranty Association or any similar organization in another state could assert claims against the commissioner of insurance, and shall further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of such payments made or to be made by the Insurance Guaranty Association or any similar organization in another state, then disbursements shall be in the amount of available assets.

D. Notice of such application shall be given to the Insurance Guaranty Association, the similar organization of each other state, and to the commissioners of insurance of each of the states. Any such notice shall be deemed to have been given when deposited in the United States mail, certified and postage prepaid, at least thirty days prior to submission of such application to the court. Action on the application may be taken by the court, provided the above required notice has been given, and provided further that the proposal complies with Subsections A, B, and C of this Section.

E. Any time after the last day fixed for the filing of proofs of claim in the liquidation of a domestic insurer, the court may, upon the application of the commissioner of insurance, authorize him to declare out of the funds remaining in his hands after the payment of expenses, one or more dividends upon all claims allowed. Such order shall specify what claims, if any, are entitled to priority of payment and shall direct the manner in which dividends shall be paid.

F. If there has been no adjudication of insolvency, the commissioner of insurance shall pay all allowed claims in full and shall distribute the balance of the assets remaining in his hands after reserving sufficient assets for all administration costs and fees, in accordance with the direction of the court. The commissioner of insurance shall not be chargeable for any assets so distributed to any claimant who has failed to file a proper proof of claim before such distribution has been made.

G. If subsequent to an adjudication of insolvency, pursuant to R.S. 22:748, a surplus is found to exist after the payment in full of all allowed claims which have been duly filed prior to the last date fixed for the filing thereof and the setting aside of a reserve for all costs and expenses of the proceeding, the court shall set a new date for the filing of claims. After the expiration of said new date, the solvency of such insurer shall be reexamined and if such insurer is then found to be solvent on the basis of all claims then filed and allowed, any surplus existing shall be distributed in accordance with the direction of the court.

H. Dividends remaining unclaimed or unpaid in the hands of the commissioner of insurance for six months after the final order of distribution may be by him deposited in one or more state or national banks, trust companies, or savings banks to the credit of the commissioner of insurance, whomsoever he may be, in trust for the person entitled thereto, but no such person shall be entitled to any interest upon such deposit. All such deposits shall be entitled to priority of payment in case of the insolvency or voluntary or involuntary liquidation of the depository on an equality with any other priority given by the banking law. Any such funds together with interest, if any, paid or credited thereon, remaining and unclaimed in the hands of the commissioner of insurance in trust after five years shall be by him paid to the state treasurer to be credited to the funds received from insurance revenues.

Acts 1958, No. 125. Amended by Acts 1981, No. 412, §1.

§756. Grounds for conservation of assets of an authorized foreign or alien insurer or an unauthorized insurer writing business on a surplus line basis

A. Whenever the property of a foreign or alien insurer authorized to do business in Louisiana or an unauthorized insurer writing business in this state on a surplus line basis has been sequestrated in its domiciliary sovereignty or elsewhere, or whenever any of the grounds specified in R.S. 22:733(A) except Paragraphs (8) and (16) arise or exist with reference to any foreign or alien insurer authorized to transact business in this state or an unauthorized insurer writing business in this state on a surplus line basis and having assets in this state, the commissioner of insurance may proceed for the filing of a petition as provided in this Part against domestic insurers, for an order directing such authorized foreign or alien insurer or such unauthorized insurer to show cause why the commissioner of insurance should not take possession of its assets in this state and conserve such assets for the benefit of its creditors and for such other relief as the nature of the cause and the interests of its policyholders, creditors, members, stockholders, or the public may require.

B. The court shall have jurisdiction over matters brought by or against the Department of Insurance or the commissioner of insurance to issue injunctions and to enter such other orders as it may deem necessary as is provided in the case of a petition against a domestic insurer so far as such injunctions or orders may apply to such foreign or alien insurer. If the court finds that sufficient cause for conservation exists, it shall direct the commissioner of insurance to take possession of the property, business, and affairs of the insurer and to conserve the same.

C.(1) Upon the entry of such order, the commissioner of insurance shall forthwith take possession of the property, business, and affairs of such foreign or alien insurer, and conserve the same. He shall retain such possession until, on the petition either of the commissioner of insurance or of such foreign or alien insurer, or its receiver or anyone in charge of the property, business, and affairs of such foreign or alien insurer in its domiciliary sovereignty, the court, after a full hearing, shall find that the ground for such order finding cause for conservation has been removed.

(2) No auditor or investigator shall be appointed or designated in connection with the conservation if he audited or investigated the foreign or alien insurer prior to the conservation.

D. The rights, powers, and duties of the commissioner of insurance as such conservator, with reference to the assets of a foreign or alien insurer shall be ancillary to the rights, powers, and duties imposed upon any receiver or other person, if any, in charge of the property, business and affairs of such insurer in its domiciliary sovereignty. When such domiciliary sovereignty is also a "reciprocal state" as defined in R.S. 22:757, the commissioner of insurance, as ancillary receiver in this state, shall be subject to the provisions of the Uniform Insurers Liquidation Law (R.S. 22:757 through 763) herein.

Acts 1958, No. 125. Amended by Acts 1970, No. 86, §1; Acts 1991, No. 742, §1; Acts 1992, No. 808, §1, eff. July 7, 1992; Acts 1993, No. 955, §1.

§756.1. Provisions for conservation of assets of domestic company

A. Upon the filing by the commissioner of insurance of a verified petition alleging that with respect to a domestic company a condition exists that would justify a court order for proceedings under R.S. 22:734, and that the interests of creditors, policyholders, or the public will probably be endangered by delay, then the court of the parish of East Baton Rouge or the court of the parish in which such company has or last had its principal office, shall issue forthwith without a hearing its order directing the commissioner of insurance to take possession and control of the property, business, books, records, and accounts of the company and of the premises occupied by it for the transaction of its business, or such part of each as the petition shall specify, and enjoining the company and its officers, directors, agents, servants, and employees from disposition of its property and from transaction of its business except with the concurrence of the commissioner of insurance until the further order of the court.

B. The order shall continue in force and effect for such time as the court deems necessary for the commissioner of insurance to ascertain the condition and situation of the company. On motion of either party or on its own motion, the court may from time to time hold such hearings as it deems desirable, and may extend, shorten or modify the terms of the seizure order. So far as the court deems it possible, the parties shall be given adequate notice of such hearings. As soon as practicable, the court shall vacate the seizure order, either when the commissioner of insurance has failed to institute proceedings under R.S. 22:734 having a reasonable opportunity to do so, or upon an order of the court pursuant to such proceedings.

C. Entry of a seizure order under this Section shall not constitute an anticipatory breach of any contract of the company.

D. The court may hold all hearings in conservation proceedings privately in chambers, and shall do so on request of any officer of the company proceeded against.

E. In conservation proceedings and judicial reviews thereof, all records of the company, other documents, and all insurance department files and court records and papers, so far as they pertain to and are a part of the record of the conservation proceedings, shall be and remain confidential except as is necessary to obtain compliance therewith, unless and until the court, after hearing arguments in chambers from the commissioner of insurance and the company, shall decide otherwise, or unless the company requests that the matter be made public.

F. Any person having possession of and willfully refusing to deliver any of the property, business, books, records or accounts of a company against which a seizure order has been issued shall be punishable by a fine of not more than $500.00 or imprisonment for not more than six months, or both.

G. No individual shall be selected or designated by the commissioner of insurance or the court as a conservator of a domestic insurer in conservation if the individual audited or investigated the insurer prior to its conservation.

Added by Acts 1970, No. 82, §1; Acts 1991, No. 742, §1; Acts 1992, No. 808, §1, eff. July 7, 1992; Acts 1993, No. 955, §1.

§756.2. Payments to Insurance Guaranty Association

The commissioner of insurance shall make periodic partial payments to the Insurance Guaranty Association.

Added by Acts 1970, No. 83, §1.

§757. Uniform Insurers Liquidation Law

This Section, and R.S. 22:758 through 22:763, comprise and may be cited as the "Uniform Insurers Liquidation Law". For the purposes of the law:

(1) "Insurer" means any person, firm, corporation, association, or aggregation of persons doing an insurance business and subject to the insurance supervisory authority of, or to liquidation, rehabilitation, reorganization, or conservation by, the commissioner of insurance, or the equivalent insurance supervisory official of another state.

(2) "Delinquency proceeding" means any proceeding commenced against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving such insurer.

(3) "State" means any state of the United States, and also the District of Columbia, Alaska, Hawaii and Puerto Rico.

(4) "Foreign country" means territory not in any state.

(5) "Domiciliary state" means the state in which an insurer is incorporated or organized, or in the case of an insurer incorporated or organized in a foreign country, the state in which such insurer, having become authorized to do business in such state, has, at the commencement of delinquency proceedings, the largest amount of its assets held in trust and assets held on deposit for the benefit of its policyholders or policyholders and creditors in the United States; and any such insurer is deemed to be domiciled in such state.

(6) "Ancillary state" means any state other than a domiciliary state.

(7) "Reciprocal state" means any state other than this state in which in substance and effect the provisions of this law are in force, including the provisions requiring that the insurance commissioner or equivalent insurance supervisory official be the receiver of a delinquent insurer.

(8) "General assets" means all property, real, personal, or otherwise, not specifically or, as a result of separate accounts established under Part XXXII of Chapter 1 of this Title, deemed to be mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or a limited class or classes of persons, and as to such specifically encumbered property the term includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and assets held on deposit for the security or benefit of all policyholders, or all policyholders and creditors in the United States, shall be deemed general assets.

(9) "Preferred claim" means any claim with respect to which the law of a state or of the United States accords priority of payment from the general assets of the insurer.

(10) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any general assets.

(11) "Secured claim" means any claim secured or, as a result of separate accounts established under Part XXXII of Chapter 1 of this Title, deemed to be secured by mortgage, trust, deed, pledge, deposit as security, escrow, or otherwise, but not including special deposit claim or claims against general assets. The term also includes claims which more than four months prior to the commencement of delinquency proceedings in the state of the insurer's domicile have become liens upon specific assets by reason of judicial process.

(12) "Receiver" means receiver, liquidator, rehabilitator, or conservator as the context may require.

Acts 1958, No. 125; Acts 1993, No. 785, §1.

§758. Conduct of delinquency proceedings against insurers not domiciled in this state

A. Whenever under the laws of this state an ancillary receiver is to be appointed in delinquency proceedings for an insurer not domiciled in this state, the court shall appoint the commissioner of insurance as ancillary receiver. The commissioner of insurance shall file a petition requesting the appointment if he finds that there are sufficient assets of such insurer located in this state to justify the appointment of an ancillary receiver, or if ten or more persons residing in this state having claims against such insurer file a petition with the commissioner of insurance requesting the appointment of such ancillary receiver.

B. The domiciliary receiver for the purpose of liquidating an insurer domiciled in a reciprocal state, shall be vested by operation of law with the title to all of the property, contracts, and rights of action, and all of the books and records of the insurer located in this state, and he shall have the immediate right to recover balances due from local agents and to obtain possession of any books and records of the insurer found in this state. He shall also be entitled to recover the other assets of the insurer located in this state except that upon the appointment of an ancillary receiver in this state, the ancillary receiver shall during the ancillary receivership proceedings have the sole right to recover such other assets. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this state, and shall pay the necessary expenses of the proceedings. All remaining assets he shall promptly transfer to the domiciliary receiver. Subject to the foregoing provisions the ancillary receiver and his deputies shall have the same powers and be subject to the same duties with respect to the administration of such assets, as a receiver of an insured domiciled in this state.

C. The domiciliary receiver of an insurer domiciled in a reciprocal state may sue in this state to recover any assets of such insurer to which he may be entitled under the laws of this state.

Acts 1958, No. 125; Acts 1992, No. 808, §1, eff. July 7, 1992; Acts 1993, No. 955, §1.

§759. Claims of nonresidents against domestic insurers

A. In a delinquency proceeding begun in this state against an insurer domiciled in this state, claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary receiver. All such claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

B. Controverted claims belonging to claimants residing in reciprocal states may either (1) be proved in this state as provided by law, or (2) if ancillary proceedings have been commenced in such reciprocal states, may be proved in those proceedings. In the event a claimant elects to prove his claim in ancillary proceedings, if notice of the claim and opportunity to appear and be heard is afforded the domiciliary receiver of this state as provided in R.S. 22:760 with respect to ancillary proceedings in this state, the final allowance of such claim by the courts in the ancillary state shall be accepted in this state as conclusive as to its amount, and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within the ancillary state.

Acts 1958, No. 125.

§760. Claims against foreign insurers

A. In a delinquency proceeding in a reciprocal state against an insurer domiciled in that state, claimants, against such insurer, who reside within this state may file claims either with the ancillary receiver, if any, appointed in this state, or with the domiciliary receiver. All such claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceeding.

B. Controverted claims belonging to claimants residing in this state may either (1) be proved in the domiciliary state as provided by the law of that state, or (2) if ancillary proceedings have been commenced in this state, be proved in those proceedings. In the event that any such claimant elects to prove his claim in this state, he shall file his claim with the ancillary receiver in the manner provided by the law of this state for the proving of claims against insurers domiciled in this state, and he shall give notice in writing to the receiver in the domiciliary state, either by registered mail or by personal service at least forty days prior to the date set for hearing. The notice shall contain a concise statement of the amount of the claim, the facts on which the claim is based, and the priorities asserted, if any. If the domiciliary receiver, within thirty days after the giving of such notice, shall give notice in writing to the ancillary receiver and to the claimant, either by registered mail or by personal service, of his intention to contest such claim, he shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim. The final allowance of the claim by the courts of this state shall be accepted as conclusive as to its amount, and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within this state.

Acts 1958, No. 125.

§761. Priority of certain claims

A. In a delinquency proceeding against an insurer domiciled in this state, claims owing to residents of ancillary states shall be preferred claims if like claims are preferred under the laws of that state. All such claims owing to residents or nonresidents shall be given equal priority of payment from general assets regardless of where such assets are located.

B. In a delinquency proceeding against an insurer domiciled in a reciprocal state, claims owing to residents of this state shall be preferred if like claims are preferred by the laws of that state.

C. The owners of special deposit claims against an insurer for which a receiver is appointed in this or any other state shall be given priority against their several special deposits in accordance with the provisions of the statutes governing the creation and maintenance of such deposits. If there is a deficiency in any such deposit so that the claims secured thereby are not fully discharged therefrom, the claimants may share in the general assets, but such sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

D. The owner of a secured claim against an insurer for which a receiver has been appointed in this or any other state may surrender his security and file his claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. If the amount of the deficiency has been adjudicated in ancillary proceedings as provided in this Part, or if it has been adjudicated by a court of competent jurisdiction in proceedings in which the domiciliary receiver has had notice and opportunity to be heard, such amount shall be conclusive; otherwise the amount shall be determined in the delinquency proceeding in the domiciliary state.

E. Whenever a receiver is appointed for an insurer that has established one or more separate accounts under the provisions of Part XXXII of Chapter 1 of this Title, each of which is deemed subject to a statutory security interest in favor of the holders of that separate account, the receiver shall segregate the encumbered assets of each separate account, holding them separate and apart from the general assets of the insurer until such time as said assets are liquidated. Upon the liquidation of the assets of each separate account, the receiver shall distribute the proceeds pro rata among the owners of such separate account, or effect a distribution of such proceeds in a manner designed to preserve the tax status of such account.

Acts 1958, No. 125; Acts 1993, No. 785, §1.

§762. Attachment and garnishment of assets

During the pendency of delinquency proceedings in this or any reciprocal state no action or proceeding in the nature of an attachment, garnishment, or execution shall be commenced or maintained in the courts of this state against the delinquent insurer or its assets. Any lien obtained by any such action or proceeding within four months prior to the commencement of any such delinquency proceeding or at any time thereafter shall be void as against any rights arising in such delinquency proceeding.

Acts 1958, No. 125.

§763. Uniformity of interpretation

This Uniform Insurers Liquidation Law (R.S. 22:757 through 22:763) shall be so interpreted and construed as to effectuate its general purpose to make uniform the law of those states that enact it.

Acts 1958, No. 125.

§764. Voluntary dissolution

A. A domestic insurer may, after a two-thirds affirmative vote of its stockholders, policyholders or subscribers, voluntarily discontinue its business and dissolve its corporate existence by (1) consolidation or merger, (2) reinsuring its entire business under Part XX, or (3) cancelling its policy obligations and refunding the pro rata unearned premiums thereon, except as to its life insurance contracts, which shall be reinsured pursuant to Part XX.[1] After adequate provision has been made for the protection of its policyholders and creditors, such domestic insurer may petition the commissioner of insurance to distribute its remaining assets to its stockholders, policyholders or subscribers as may be provided in a dissolution agreement. No such plan of voluntary dissolution under this Section shall be effective until approved in writing by the commissioner of insurance.

B. When the commissioner of insurance has determined that all the proper steps have been taken and that adequate provision has been made to protect the policyholders and creditors of the retiring insurer, he shall issue a formal certificate of dissolution to such insurer.

Acts 1958, No. 125.

[1]R.S. 22§941 to 22§945.

§§765. – §767. [Blank]

§768. Administrative supervision; commissioner

A. An insurer shall be subject to administrative supervision by the commissioner if upon examination or at any other time it appears in the discretion of the commissioner that:

(1) The condition of the insurer renders the continuance of its business hazardous to the public or its insureds.

(2) The insurer appears to have exceeded its powers granted under its certificate of authority and any applicable law.

(3) The insurer has failed to comply with the applicable provisions of the Louisiana Insurance Code.

(4) The business of the insurer is being conducted fraudulently.

(5) The insurer grants its consent.

B. If the commissioner determines that any of the conditions set forth in Subsection A of this Section exist, the commissioner shall:

(1) Notify the insurer of his determination.

(2) Furnish to the insurer a written list of the requirements to abate this determination.

(3) Notify the insurer that it is under administrative supervision in accordance with the provisions of R.S. 22:768 through 773. This determination by the commissioner shall be subject to review in accordance with the Administrative Procedure Act.

C. If placed under administrative supervision, the insurer shall within sixty days, or within another period not to exceed one hundred twenty days prescribed by the commissioner, comply with the requirements directed by the commissioner pursuant to the provisions of R.S. 22:768 through 773.

D. If the commissioner determines after due notice and proper hearing that the conditions which precipitated the administrative supervision still exist, he may extend the period of supervision.

E. If the commissioner determines that none of these conditions still exist, the commissioner shall release the insurer from supervision.

Acts 1991, No. 997, §1.

§769. Confidentiality of certain proceedings and records; immunity of certain staff

A. Notwithstanding any other provision of law, all proceedings, hearings, notices, correspondence, reports, and other information in the possession of the commissioner or the department of insurance relating to the supervision of any insurer are confidential, except as otherwise provided in this Section.

B. The personnel of the Department of Insurance shall have access to these proceedings, hearings, notices, correspondence, reports, records, or information to the extent permitted by the commissioner.

C. The commissioner may open the proceedings or hearings, or disclose the notices, correspondence, reports, records, or information to any department, agency, or other instrumentality of the state or of the United States if the opening or disclosure is necessary or proper for the enforcement of the laws of this or any other state of the United States.

D. The provisions of this Section shall not apply to hearings, notices, correspondence, reports, records, or other information obtained upon appointment of a receiver for the insurer by a court of competent jurisdiction.

E. There shall be no liability on the part of and no cause of action of any nature shall arise against any employee, agent, or representative of the Department of Insurance for any action taken by him in the performance of his powers and duties under the proceedings of this Section.

Acts 1991, No. 997, §1.

§770. Prohibited acts during period of supervision

During the period of administrative supervision, the commissioner or his designee shall serve as the administrative supervisor of the insurer. The commissioner may require that the insurer not do any of the following during the period of supervision without his or his designee's prior written approval:

(1) Dispose of, convey, or encumber any of its assets, liabilities, or business in force.
(2) Withdraw any monies, or contents therein, of its bank accounts.
(3) Lend any of its funds.
(4) Invest any of its funds.
(5) Transfer any of its property.
(6) Incur any debt, obligation, or liability.
(7) Merge or consolidate with another company.
(8) Approve new premiums or renew any policies.
(9) Enter into any new reinsurance contract or treaty.
(10) Terminate, surrender, forfeit, convert, or lapse any insurance policy, certificate, or contract, except those obligations for nonpayment of premiums due.
(11) Release, pay, or refund premium deposits, accrued cash or loan values, unearned premiums, or other reserves on any insurance policy, certificate, or contract.
(12) Make any material change in management.
(13) Increase salaries and benefits of officers or directors or the payment of bonuses, dividends, or other payments deemed preferential.

Acts 1991, No. 997, §1.

§771. Review and stay of action; supervision

During the period of supervision, the insurer may contest an action taken or proposed to be taken by the supervisor, specifying the manner wherein the action being complained of would not result in improving the condition of the insurer. Denial of the insurer's request upon reconsideration shall entitle the insurer to request the appropriate review of administrative procedures.

Acts 1991, No. 997, §1.

§772. Administrative election of proceedings

Nothing contained in this Part shall preclude the commissioner from initiating judicial proceedings in conservation, rehabilitation, or liquidation proceedings or other delinquency proceedings, however designated under the laws of the state, regardless of whether the commissioner has previously initiated administrative supervision under this Part against the insurer.

Acts 1991, No. 997, §1.

§773. Administrative rules

The commissioner may adopt reasonable rules, including fines and penalties for violations of R.S. 22:770, necessary for the implementation of the provisions herein, pursuant to the Administrative Procedure Act.

Acts 1991, No. 997, §1.

§774. Expenses of supervision; payment by insurer

A. All expenses incurred by the commissioner in conducting an administrative supervision shall be paid by the insurer being supervised. An insurer may contest the reasonableness of the amount of the expenses billed to it by applying to a court of competent jurisdiction for a rule to test the reasonableness of the billing. The rule shall be tried by preference and, if appealed, shall be given preference in the appellate court as may be provided for suits against the state.

B. If a supervised insurer does not contest the reasonableness of the billing and fails to pay the expenses of the examination within thirty days after the receipt of the billing or within fifteen days after the date that a final judgment was rendered when a rule had been issued pursuant to Subsection A of this Section, the commissioner may file a lien against any of the assets of the supervised insurer located within the state until the amount of the lien is paid in full.

C. The commissioner may issue such rules, regulations, or orders as are necessary to carry out and implement the provisions of this Part pursuant to the Administrative Procedure Act.

Acts 1992, No. 437, §1; Acts 1999, No. 1304, §1, eff. July 12, 1999.

PART XVII. CONVERSION

§801. Conversion requirements

A. After the effective date of this Section, no domestic life insurer may convert to a type of insurer having greater insuring power without meeting the full capital, surplus, and deposit requirements of the type insurer to which it desires to convert.

B. REPEALED BY ACTS 1997, No. 1449, §2.

Acts 1958, No. 125. Amended by Acts 1960, No. 167, §1; Acts 1975, No. 575, §1; Acts 1997, No. 1449, §2.

§§802 – §805. REPEALED BY ACTS 1975, No. 575, §2

§806. Stock and mutual conversions

No domestic insurer may convert from a stock to a mutual, or from a mutual to a stock insurer, or from any type insurer to any other type insurer, except as provided in R.S. 22:801 unless a plan of conversion is submitted to and approved by the commissioner of insurance.

The commissioner of insurance shall not approve any such conversion unless in his opinion after a full investigation, and hearing if he deems it necessary, the best interests of the policyholders of any such insurer will be served.

Acts 1958, No. 125.

PART XVII-A. MUTUAL INSURANCE HOLDING COMPANIES

§820. Mutual insurance holding companies

A domestic mutual insurance company, upon approval of the commissioner, may reorganize by forming a mutual insurance holding company based upon a mutual plan or by merging its policyholders' membership interests into such a mutual insurance holding company. The reorganized insurance company shall continue, without interruption, its corporate existence as a stock insurance company subsidiary to the mutual insurance holding company or as a stock insurance company subsidiary to an intermediate holding company which is a subsidiary of the mutual insurance holding company. A reorganization under this Section is subject to the provisions of R.S. 22:1001 et seq., the Insurance Holding Company System Regulatory Law.

Acts 1997, No. 1482, §1.

NOTE: SEE ACTS 1997, NO. 1482, §2, REGARDING NON-APPLICABILITY TO CERTAIN NONPROFIT MUTUAL ASSOCIATIONS.

§821. Applicability of demutualization provisions

Part XVII of this Chapter is applicable to a demutualization of a mutual insurance holding company which resulted from the reorganization of a domestic mutual insurance company reorganized under this Part as if it were a mutual insurance company. Part XVII of this Chapter is not applicable to a reorganization or merger pursuant to this Part.

Acts 1997, No. 1482, §1.

PART XVIII. INVESTMENTS OF DOMESTIC INSURERS

§841. Authorized investments

The capital, surplus, assets and other funds of insurers organized under the laws of this state shall be invested as provided in this Part and not otherwise.

Acts 1958, No. 125.

§842. General qualifications

No security or other investment shall be eligible for purchase or acquisition under this Part unless it is interest bearing or interest accruing or dividend or income paying or eligible for dividends or income, is not then in default in any respect, and the insurer is entitled to receive for its exclusive account and benefit, the interest or income accruing thereon; except that it may acquire real property for occupancy by the insurer for home and branch office purposes, and as provided in R.S. 22:844 and 845. No security shall be eligible for purchase at a price above its market value.

Acts 1958, No. 125; Acts 2001, No. 61, §1.

§843. General limitation on investment in obligations of any one person

An insurer shall not, except with the consent of the commissioner of insurance, have at any time any combination of investments in or loans upon the security of the obligations, property, and securities of any one person or institution aggregating an amount exceeding five per cent of the insurer's assets, except in the case of mortgage loans as provided in R.S. 22:844 A(5) and in case of investments in stocks of corporations owning funeral homes as provided in R.S. 22:844 C. This Section shall not apply to investments in, or loans upon the security of general obligations of the government of the United States or of any state or territory of the United States, or the District of Columbia nor to investments in foreign securities pursuant to Sub-section A, R.S. 22:846, nor include policy loans made pursuant to Sub-section E of R.S. 22:844.

Acts 1958, No. 125.

§844. Investments in securities

A. Any domestic insurer may invest in the following securities:

(1) Bonds or securities not in default as to principal or interest, which are the direct obligations of or which are secured or guaranteed as to principal and interest by the United States, any state or territory of the United States, or the District of Columbia where there exists the power to levy taxes for the prompt payment of the principal and interest of such bonds or evidences of indebtedness and any federal farm loan bonds issued by federal land banks, debentures issued by federal intermediate credit banks, and debentures issued by banks for cooperatives. Nothing in this Part shall prohibit the acquisition by a domestic insurer of United States government securities, the purchases of which are otherwise permitted under this Part in accordance with the Federal Reserve System United States Treasury Department program relating to the utilization of book entry record keeping procedures.

(2) Bonds or evidences of indebtedness which are direct general obligations of any county, parish, city, town, village, school district, drainage district, sanitary district, park district, or other political subdivision or municipal corporation of this state or any other state or territory of the United States or the District of Columbia which shall not be in default in the payment of any of its general obligation bonds, either principal or interest, at the date of such investment.

(3) Bonds of any levee or other board of this state, and obligations issued or guaranteed by the International Bank for Reconstruction and Development, or the Asian Development Bank.

(4) Investment grade bonds or other obligations which are payable from revenues or earnings specifically pledged therefor of a public utility, state or municipally owned, either directly or through any civil divisions, authority or public instrumentality of a state or municipality, provided that the laws of the state or municipality authorizing the issuance of such bonds or other obligations require that rates for service shall be fixed, maintained, and collected at all times so as to produce sufficient revenue or earnings to pay all operating and maintenance charges and both principal and interest of such bonds or obligations, and provided further that no such bonds or other obligations shall be in default at the date of such investment; and investment grade bonds or evidences of indebtedness, which are payable from tax revenues of any parish, city, town, village, school district, drainage district, sanitary district, park district, or other political subdivision or municipal corporation of this state or any territory of the United States or the District of Columbia, which shall not be in default in the payment of any of its general obligation bonds or tax revenue bonds, either principal or interest, at the date of such investment, and which shall have sufficient tax revenues specifically pledged therefore at the date of such investment; however, no company shall invest an aggregate of more than thirty-three and one-third per centum of its admitted assets in bonds or other obligations described in this Paragraph and also those described in R.S. 22:844(A)(13).

(5)(a)(i) First mortgages on improved unencumbered real estate or bonds secured thereby located within any of the states of the United States or the District of Columbia, including leasehold estates in improved unencumbered real property having an unexpired term of not less than twenty-one years inclusive of the term which may be provided by an enforceable option of renewal, in an amount not exceeding eighty per centum of the appraised value, said appraised value to be substantiated by the appraisal by a recognized and experienced real estate appraiser who is a member of a recognized appraisal organization, which the commissioner of insurance may accept if he is satisfied that the appraiser is competent and disinterested. Before making such investment, a certificate of the value of such property, based on such appraisal shall be executed by the board of directors, by an investment committee, or by a member of the board of directors making or authorizing such investment on behalf of the insurer, provided that the investment in any one mortgage, any one issue of bonds, or any one contract for deed does not exceed ten per centum of the company's admitted assets.

(ii) No mortgage loan upon a leasehold shall be made or acquired by an insurer pursuant to this Paragraph unless the terms thereof shall provide for amortization payments to be made by the borrower on the principal thereof at least once in each year in amounts sufficient to amortize the loan completely within a period of four-fifths of the term of the leasehold, inclusive of the term which may be provided by an enforceable option of renewal, which is unexpired at the time the loan is made, but in no event exceeding thirty-five years.

(b) Subject to the provisions of Subparagraph (a), any domestic insurer may invest in obligations secured by mortgages or deeds of trust on real property otherwise encumbered only by a first mortgage or first deed of trust, subject to the following conditions:

(i) The aggregate value of both mortgages or deeds of trust does not exceed eighty percent of the appraised value; and

(ii) The obligation is secured by a wrap-around mortgage where:

(aa) Only one preexisting mortgage or deed of trust encumbers the real property.

(bb) The mortgage or deed of trust securing the loan is recorded and is insured under a policy of title insurance in an amount not less than the total amount of the obligation of the borrower to the insurer under the loan.

(cc) The insurer agrees as part of the wrap-around mortgage agreement to make the payments due under the first mortgage or first deed of trust upon receipt of payments due from the borrower under the wrap-around mortgage.

(c) For all purposes of this Part, the wrap-around mortgage or deed of trust shall be treated in the same manner as if the insurer held the first mortgage or deed of trust.

(d) As used in this Subsection, "improved real estate" means all farmland which has been reclaimed and is used for the purpose of husbandry, whether for tillage, pasture, or improved forestation, and all other real property on which permanent buildings suitable for residence or commercial use are situated, including but not limited to condominium property, as defined in R.S. 9:1122.101 through 1124.115.

(e) Real property for the purpose of this Subsection shall not be deemed to be encumbered within the meaning of this Section by reason of the existence of instruments reserving rights of way, sewer rights, and rights in walls, nor by reason of building restrictions or other restrictive covenants, nor by the reason of the fact that it is subject to lease under which rents or profits are reserved to the owner. The security for such investment shall be a full and unrestricted first lien or mortgage upon such real property, and there shall be no condition nor right of reentry or forfeiture under which such investments can be cut off, subordinated, or otherwise disturbed. Structures thereon must be insured for an amount not less than the appraised value of such structures, and the proceeds of the policy shall be payable to and held by the company or a trustee for its benefit. The insurance shall be continued in force as long as the loan continues.

(f) Notwithstanding the restrictions herein set forth, any domestic insurer may, to the full extent of the amount insured or guaranteed, invest:

(i) In bonds or notes secured by a mortgage or trust deed issued, assumed, guaranteed, or insured by the United States, by any agency of the United States, or by any state;

(ii) In securities issued or mortgages guaranteed by the Federal National Mortgage Association or other similar corporations regulated by any agency of the United States; and

(iii) In securities issued by other entities and secured by conventional first mortgage loans. When such loans exceed the loan-to-value ratio of eighty percent, said loans shall be covered by private mortgage insurance to the extent that the loan-to-value ratio exceeds eighty percent.

(iv) In bonds issued, assured, and guaranteed by the Inter-American Development Bank and the African Development Bank.

(g) Notwithstanding the restrictions herein set forth, the amount of any first mortgage investment as limited by Subparagraph (a) of this Paragraph herein may be exceeded if and to the extent that such excess shall be guaranteed by the administrator of veterans affairs pursuant to the provisions of Title III of an Act of Congress of the United States on June 22, 1944, entitled the Servicemen's Readjustment Act of 1944,[1] as heretofore or hereafter amended.

(h) No such domestic insurer shall invest in any manner, either directly or indirectly by means of corporations, holding companies, trustees, or otherwise, in real estate securities junior to first mortgages, except as set forth above and in Subsection H of this Section. Such domestic insurer shall not invest in excess of sixty-six and two-thirds per centum of its admitted assets in the securities described herein and in Subsection G of this Section.

(i) Participation or pass through interests representing an ownership interest in bonds, notes, or other evidences of indebtedness, which are entitled to receive both principal and interest, and are secured or backed by mortgage loans or trust deeds, subject to the following:

(i) All participation or pass through interests shall:

(aa) Maintain a minimum quality rating of one or two by the National Association of Insurance Commissioners, Securities Valuation Office, or if unrated shall be promptly submitted, upon acquisition, to the National Association of Insurance Commissioners, Securities Valuation Office, and receive a minimum quality rating of one or two; and

(bb) Retain a servicing agent or other person obligated to distribute all payments, proceeds, and recoveries from the participation and pass through interests, after deduction of reasonable fees and expenses, to the participants as provided by the trust or participation agreement for the issue.

(ii) Notification by the domestic insurer to the servicing agent, or other person obligated to make distributions, of any transfer of interest, by pledge or otherwise, in participation or pass through interests.

(iii) The investments by the domestic insurer in any one issue described by this Subparagraph shall not exceed five percent of the admitted assets of the domestic insurer and the total amount of the investments of the domestic insurer in all issues described by this Subparagraph shall not exceed forty percent of the admitted assets of the domestic insurer, provided however any direct United States agency issued or United States government guaranteed bonds, participating or pass through interests, or other evidences of indebtedness shall not be included under nor limited herein.

(iv) The interests of the domestic insurer in the participation or pass through interests and mortgage loans or trust deeds shall be superior to the interests of the ordinary creditors of the servicing agent, or other person obligated to make distributions, and shall also be superior to any federal regulatory authority having jurisdiction over the servicing agent, or other person obligated to make distribution, in the event of the insolvency or other failure of the servicing agent, or other person obligated to make distributions.

(6) Subject to the limit set forth in Subsection B, bonds or evidences of indebtedness issued or guaranteed by any railroad corporation or corporations (other than those organized and chartered for the sole purpose of holding stocks of other corporations) created under the laws of the United States or of any of the states of the United States or the District of Columbia or any certificates of any equipment trust created on behalf of any such railroad corporation; provided that such bonds or certificates have not been in default as to principal or interest payments during any of the five years next preceding the date of such investment or during the tenure of such issue if issued less than five years prior to such investment, and provided further that no insurer shall invest in any one issue of such bonds, certificates or evidences of indebtedness, an amount in excess of two per cent of such insurer's admitted assets.Such domestic insurer shall not invest in excess of thirty-three and one-third per centum of its admitted assets in bonds, certificates, or other evidences of indebtedness described in this paragraph.

(7)(a) Subject to the limit set forth in Subsection B of this Section, bonds or evidences of indebtedness issued or guaranteed by any solvent public utility corporation or corporations, other than those organized and chartered for the sole purpose of holding the stocks of other corporations, created under the laws of the United States or of any of the states of the United States or the District of Columbia, provided that such bonds or evidences of indebtedness are not in default either as to principal or interest and provided no insurer shall invest in any one issue of such bonds or evidences of indebtedness, an amount in excess of two percent of the insurer's admitted assets.

(b) Such domestic insurer shall not invest in excess of fifty percent of its admitted assets in bonds or other evidences of indebtedness described in this Paragraph.

(8)(a) Subject to the limit set forth in Subsection B of this Section, bonds or evidences of indebtedness issued or guaranteed by any solvent corporation or corporations, other than those mentioned in Paragraphs (6) and (7) and other than corporations organized and chartered for the sole purpose of holding the stocks of other corporations, created under the laws of the United States or of any of the states of the United States or the District of Columbia, provided that no insurer shall invest in any one issue of any such bonds or evidences of indebtedness an amount in excess of two percent of such domestic insurer's admitted assets except as provided in Subsection D of this Section, and provided that the corporation issuing such bonds or evidences of indebtedness shall have paid the prescribed interest thereon during each of the five years next preceding the date of such investment, or the tenure of such issue if issued less than five years prior to such investment.

(b) Such domestic insurer shall not invest in excess of fifty percent of its admitted assets in bonds or other evidences of indebtedness described in this Paragraph, except as provided in Subsection D of this Section.

(9) Subject to the limit set forth in Subsection B, preferred or guaranteed stocks issued or guaranteed by any solvent corporation or corporations, except the stocks of other insurance companies, created under the laws of the United States or any of the states of the United States or the District of Columbia; provided that no insurer shall invest in any one issue of any such preferred or guaranteed stocks in an amount in excess of two percent of such insurer's admitted assets; and provided further that no such stocks shall be purchased unless the prescribed dividends are being paid thereon.

Such domestic insurer shall not invest in excess of twenty-five percent of its admitted assets in the stocks described in this Paragraph; but in no event shall it invest in common stocks, other than guaranteed stocks, except as provided in Subsections C and D; nor shall it invest in or loan any of its funds on its own stock.

(10) Loans upon the pledge of bonds, mortgages, securities, stock or evidence of indebtedness acceptable as investment for the lending insurer under the terms of this Code and subject to the same limits as to each security as is provided in this Code for investment, if the face or current market value whichever is less of such mortgages is more than the amount loaned thereon, and the current market value of such bonds, securities, preferred or guaranteed stock or evidences of indebtedness is at least twenty per cent more than the amount loaned thereon. This limitation shall not apply to loans on the pledge of bonds or securities of the United States.

(11) Shares of insured state chartered building and loan or homestead associations and federal savings and loan associations, if such shares are insured by the Federal Savings and Loan Insurance Corporation as specifically set forth under the terms of Title IV of an Act of the Congress of the United States entitled the "National Housing Act." [2]

(12) Shares or securities of any open-end or closed-end management type investment company or investment trust registered under the Federal Investment Company Act of 1940, as from time to time amended, which men of prudence, discretion, and intelligence acquire or retain for their own account; no company shall invest more than five percent of its admitted assets in any one investment or aggregate of fifty percent of admitted assets in stocks or securities described in this Paragraph.

(13) Dormitory and union building revenue bonds issued by the state board of education for the state colleges, or by the board of supervisors of Louisiana State University and Agricultural and Mechanical College, provided that the governing body of any state college or state university authorizing the issuance of such bonds requires that rates for service shall be fixed, maintained and collected at all times so as to produce sufficient revenue or earnings to pay all operating and maintenance charges and both principal and interest of such bonds, and provided, further, that no such bonds shall be in default at the date of such investment.

No company shall invest an aggregate of more than thirty-three and one-third per centum of its admitted assets in the bonds or other obligations described in R.S. 22:844(A)(4) and also those bonds described in the preceding paragraph.

(14) Bonds or other obligations issued or guaranteed by the Inter-American Development Bank.

(15) Student loan notes or other obligations which are guaranteed or insured as to principal by the Louisiana Student Financial Assistance Commission or any other authorized agency or instrumentality of the state of Louisiana or by any authorized agency or instrumentality of the United States government.

(16) The department shall have the authority to promulgate rules and regulations to further the objective of this Subsection and to establish the volatility and pricing and reporting requirements for investments authorized herein.

(17) Equipment trust obligations or certificates, or pass-through certificates, which are adequately secured evidencing an interest in equipment operated wholly or in part within the United States and have a right to receive determined portions of rental, purchase, or other fixed obligatory payments for the use or purchase of such equipment. Obligations, certificates, or pass-through certificates hereunder shall have a minimum quality rating by the National Association of Insurance Commissioners Securities Valuation Office of one or two, or if unrated, shall be promptly submitted upon acquisition to the National Association of Insurance Commissioners Securities Valuation Office and receive a minimum quality rating of one or two. Such domestic insurer shall not invest in excess of ten percent of its admitted assets in obligations, certificates, or pass-through certificates described in this Paragraph.

(18)(a) Asset-backed securities or other instruments evidencing a senior (nonsubordinated) secured interest in, and the right to receive both principal and interest payments from distributions on a pool of financial assets, other than mortgages on real property, held by a business entity on the following conditions:

(i) The business entity is established solely for the purpose of acquiring specific types of financial assets, issuing securities and other instruments representing an interest in or right to receive cash flows from those assets, and engaging in related activities.

(ii) The pool of assets consists solely of interest-bearing obligations or other contractual obligations representing the right to receive payment from the assets; however, the existence of credit enhancement or other support features such as letters of credit, guarantees, and swap agreements shall not cause a security or other instrument to be disqualified under this Section.

(b) Investments hereunder shall have a current and continuing minimum quality rating of "A" by one or more of the four nationally recognized securities rating organizations and a rating by the National Association of Insurance Commissioners Securities Valuation Office of one, or if unrated, shall be promptly submitted upon acquisition to the National Association of Insurance Commissioners Securities Valuation Office and receive a minimum quality rating of one. Such domestic insurer shall not invest in excess of one percent of its admitted assets in any one issue of asset-backed obligations or in excess of five percent of its admitted assets in the aggregate of asset-backed obligations described in this Paragraph.

B. The total investment of a domestic insurer in the securities described in Paragraphs (6) through (9), and (17) and (18) of Subsection A of this Section, subject to the limitations stated in said paragraphs, shall not exceed in the aggregate, seventy-five percent of its admitted assets.

C.(1) Any domestic life insurer, in addition to the investment permitted by Subsection A, may invest in the shares of capital stock, American Depository Receipts, which are listed on a national securities exchange, and securities of any solvent corporation (other than a corporation engaged solely in the business of owning and operating real estate, or a corporation having substantially all of its assets invested in the shares of such corporations) created under the laws of the United States, or of any of the states of the United States, or the District of Columbia, provided that the shares or American Depository Receipts of such corporation are registered on a national securities exchange, as provided in an Act of Congress of the United States, entitled the "Securities Exchange Act of 1934", approved June 6, 1934, as amended, or local exchanges, or are readily marketable, or shares of foreign corporations listed on the New York Stock Exchange or the American Stock Exchange, and provided further that such corporation is listed on a national securities exchange at the time of the investment or has earned during any three years of the five-year period next preceding the date of the investment, a sum applicable to dividends equal in the aggregate to not less than twelve percent of the par value (or, in the case of shares having no par value, the stated value) of its outstanding shares.

(2) Such insurer shall not invest more than five percent of its admitted assets in the shares or securities of any one such corporation, provided that in the case of insurers issuing funeral policies, such insurers may invest an amount not exceeding twenty-five percent of the admitted assets in the stock of a corporation owning a funeral home or homes, provided that at least ninety percent of the assets of the corporation owning a funeral home or homes shall consist of such funeral home or homes and equipment, provided such investment in the shares or securities of corporations owning a funeral home or homes was made prior to 12:00 noon of October 1, 1948.

D. Any domestic insurer, in addition to the investments permitted by Subsection A of this Section, may invest an amount equal to its capital and surplus if it is a stock company, and, if it is a company other than stock, it may invest an amount equal to its surplus over all liabilities as follows:

(1)(a) In shares of capital stock, American Depository Receipts listed on a national securities exchange, bonds, securities, or other evidences of indebtedness of any solvent corporation (other than a corporation engaged solely in the business of operating real estate or a corporation having substantially all of its assets invested in the shares of such corporation) created under the laws of the United States, or the states of the United States, or the District of Columbia, or a foreign corporation whose stock is listed on the New York Stock Exchange or the American Stock Exchange, provided that such insurer may not, except in the case of shares permitted by Paragraph (9) of Subsection A, invest in the shares or American Depository Receipts of a manufacturing corporation, commonly known as "industrial", unless such corporation is listed on a national securities exchange at the time of the investment or has earned during any three years of the five-year period next preceding the date of the investment, a sum applicable to dividends equal in the aggregate to not less than twelve percent of the par value (or, in the case of shares having no par value, the issued value) of its outstanding shares, or if such shares have been issued less than five years, has earned a sum applicable to dividends during the tenure of such issue, equal to not less than four percent per annum of the par value, (or, in the case of shares having no par value, the issued value) of its outstanding shares.

(b) Such insurers shall not invest more than five percent of its admitted assets in the shares of any one such manufacturing corporation. Such insurers may acquire the stock or other share capital of another insurer but shall not invest more than fifty percent of said funds, directly or indirectly, in shares of another insurer, nor shall such insurer acquire the whole or any part of the stock or other share capital of another insurer which transacts the same kind or kinds of insurance where the effect of such acquisition may be to substantially lessen competition generally or tend to create a monopoly. Investing in the stocks, bonds, or other evidence of indebtedness of any corporation, a substantial portion of whose funds are invested directly or indirectly in the shares of insurance companies, shall be regarded as investing indirectly in such shares. Whenever the commissioner of insurance has reason to believe that there is a violation of this Subsection, he shall hold a hearing, and if he shall find that such investment is in violation of this Subsection, he shall cause such insurer to divest itself of such investment within such reasonable time, or such extension thereof, as he shall specify. Any such order of the commissioner of insurance shall be subject to review as provided in Part XXIX.

(2) If such insurer is operating in any foreign country, in securities which are direct obligations of such foreign country or state, province or political subdivision thereof, to an amount not to exceed the total unearned premium reserve of policies issued in said foreign country, or in such an amount as it may be required by law to transact business therein, or as permitted in R.S. 22:846.

(3) An insurer may invest in, acquire debt obligations of, or otherwise acquire and hold a limited partnership interest in any limited partnership formed pursuant to the laws of any state or the United States of America and which partnership invests in assets otherwise permitted under this Part. No limited partnership interest or debt obligation shall be acquired under this Section if the cost thereof would exceed two percent of the assets of such insurer, nor if such cost, plus the book value on the date of such acquisition of all limited partnership interests or debt obligations then held by such insurer and acquired under this Section, would exceed ten percent of such assets.

E. Nothing in this Code shall prevent any life insurer from purchasing for its own benefit any policy of insurance or other obligation of the insurer or any claim of its policyholders nor from lending to any holder of a policy a sum not exceeding the reserve value of such policy at the time the loan is made, for the payment of which loan the policy and all profits thereon shall be pledged.

F. In applying the percentage limitation imposed by this Section there shall be used as a base the total of all assets which would be admitted by this Code without regard to percentage limitations.

G.(1)(a) Any domestic insurer, in addition to the other investments permitted by this Section, as provided in this Subsection, may, purchase land situated in this state, and in any other state in which the domestic insurer is licensed to do business. On such land the insurer shall erect within three years, if not already thereon, apartments, tenements, or other dwelling houses, hotels, retail stores, shops, offices, warehouses, shopping centers, funeral homes, other complexes for commercial purposes, general merchandising stores, and other community services reasonably incident to such projects.

(b) The insurer may thereafter own, hold, maintain, and manage the land so acquired and the improvements thereon and collect or receive income therefrom and may grant, sell, or convey the same in whole or in part. Ownership, management, and control shall be entire and complete by one insurer unless shared by two or more insurers subject to this Code or unless the insurer is a general partner under agreements that will assure concerted action in the management and control of the property and in case of the insolvency of any participating insurer.

(2) The aggregate investment by any such insurer under the terms of this Subsection, as evidenced by its original purchase price, shall not exceed five per cent of the admitted assets of the insurer.

(3) The combined investments by a domestic insurer under the provisions of this Subsection and Paragraph (5) of Subsection A of this Section shall not exceed sixty-six and two-thirds per cent of the admitted assets of such insurer on the December 31 next preceding such investment.

(4) REPEALED BY ACTS 2004, No. 505, §2.

(5) REPEALED BY ACTS 2004, No. 505, §2.

(6) Such orders or decisions of the commissioner of insurance shall be subject to review as provided in Part XXIX of this Chapter.

H. Any domestic insurer, in addition to the other investments permitted by this Section, may invest in an amount equal to twenty-five percent of its capital and surplus if a stock company, and if a company other than stock twenty-five percent of its surplus, or five percent of its admitted assets, whichever is the greater, in an admitted asset pursuant to this Section without regard to the percentage limitations, except that no such insurer may invest in its own stock or in real estate securities junior to first mortgages; however, if an insurer who holds a first mortgage on immovable property makes an additional loan secured by a mortgage on that immovable property, and if the total of the balance due on the original loan and the amount of the additional loan does not exceed the percentage of the appraised value of the immovable property set forth in Paragraph (5) of Subsection A of this Section, and if there are no intervening liens, the mortgage securing this additional loan shall be admitted as a first lien and mortgage. No investment under this Subsection shall be eligible for purchase at a price above its market value, nor shall any investment made under this Subsection be sold below its market value.

I.(1) Any domestic insurer, in addition to the other investments permitted by this Part, may, with the direction or approval of a majority of its board of directors or an authorized committee thereof, invest any of its funds or any part thereof in repurchase agreements whereby the principal amount of the agreement represents investments otherwise authorized by this Part.

(2) The repurchase agreement shall be in writing; shall have a specific maturity date; shall adequately identify each security to which the agreement applies; and shall state that in the event of default by the party agreeing to repurchase the securities described in the agreement at the term contained in the agreement, title to the described securities shall pass immediately to the insurance company without recourse.

J. REPEALED BY ACTS 2001, No. 61, §2.

K. REPEALED BY ACTS 2001, No. 61, §2.

L. A domestic insurer may invest in the following:

(1) Loans secured by first liens on interest in oil, gas, or condensate properties or leaseholds in the United States and Canada on which there are fully completed commercially producing wells. The value of the proved oil and gas reserves, as determined by a registered petroleum engineer, shall not be less than one hundred fifty percent of the loans thereon.

(2) Notwithstanding the provisions of Subsection H of this Section, the total of loans and investments made pursuant to this Subsection shall not exceed two percent of the insurer's assets.

M. A domestic insurer may invest in venture or seed capital investments offered by a professionally managed capital company which are certified under the provisions of Chapter 26 of Title 51 of the Louisiana Revised Statutes of 1950, in a small business investment company (SBIC), or in a minority small business investment company (MSBIC) domiciled in this state, or in any such company itself, investments of bonds or investments provided through the Louisiana Science and Technology Foundation as provided in R.S. 22:1068(E), any university research or incubator venture and opportunity, the Louisiana Small Business Development Corporation, the Louisiana Small Business Equity Corporation, and the rural relief fund, or any combination of investments and companies thereof. No insurer shall invest in excess of one percent of its available admitted assets, nor more than ten percent of the allowable one percent investment in any one venture, investment, offering, or company. No insurer shall make any such investment under this Subsection unless its statutorily mandated capitalization and surplus level is one million dollars or more, or if it is under any supervisory action or administration of the Department of Insurance. Any investment authorized by this Subsection shall be eligible for a reduction of taxes as stipulated by R.S. 22:1068 provided that either the investment or the company is in Louisiana.

N. A domestic insurer may purchase contracts for the servicing of first mortgage loans. The total investment in such contracts shall not exceed ten percent in the aggregate of the insurer's assets.

Acts 1958, No. 125. Amended by Acts 1958, No. 112, §§1, 2; Acts 1958, No. 200, §1; Acts 1960, No. 145, §1; Acts 1962, No. 51, §1; Acts 1962, No. 168, §1; Acts 1968, No. 55, §1; Acts 1970, No. 105, §1; Acts 1974, No. 694, §1; Acts 1977, No. 428, §1 to 5; Acts 1978, No. 454, §1, 2; Acts 1981, No. 679, §1; Acts 1983, No. 251, §1; Acts 1984, No. 592, §1; Acts 1984, No. 593, §1; Acts 1984, No. 594, §1; Acts 1984, No. 596, §1; Acts 1984, No. 597, §1; Acts 1984, No. 740, §1; Acts 1984, No. 742, §1; Acts 1984, No. 743, §1; Acts 1985, No. 476, §1; Acts 1985, No. 817, §1, eff. July 22, 1985; Acts 1986, No. 381, §1; Acts 1986, No. 587, §1; Acts 1990, No. 229, §1; Acts 1991, No. 1004, §1; Acts 1995, No. 1124, §1; Acts 1997, No. 988, §1; Acts 1997, No. 1449, §1; Acts 2001, No. 61, §1; Acts 2003, No. 127, §1; Acts 2004, No. 505, §§1 & 2.

[1]See 38 U.S.C.A. §3101 et seq.

[2]12 U.S.C.A. §1701 et seq.

[3]15 U.S.C.A. §80a-1 et seq.

[4]15 U.S.C.A. §78a et seq.

[5]R.S. 22:1351 et seq.

§844.1. Investment in mortgages; interest rate

Notwithstanding any other provision of law to the contrary, a domestic insurer shall be entitled to the same benefits and exemptions relative to state usury laws, specifically R.S. 9:3503 and Louisiana Civil Code Article 2924, granted to banks and savings and loan associations pursuant to Title V of the 1980 Depository Institutions Deregulation and Monetary Control Act, as amended. The rate of interest shall be fixed in writing, and testimonial proof of it shall not be admitted in any case.

Added by Acts 1981, No. 680, §1.

§844.2. Derivative transactions

A. In this Section, unless the context otherwise requires, the following definitions shall be applicable:

(1)(a) "Counterparty exposure amount" on over-the-counter derivatives means:

(i) The market value of the derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to or by the insurer; or

(ii) Zero, if the liquidation of the derivative instrument would not result in a final cash payment to or by the insurer; or

(iii) The net sum payable to or by the insurer in connection with all derivative instruments subject to the written master agreement on their liquidation in the event of default by the counterparty under the master agreement, if there are no conditions precedent to the obligations of the counterparty to make such a payment and no set off of amounts payable under any other instrument or agreement.

(b) Insurers can only enter into a written master agreement that provides for netting of payments owed by or to the respective parties if the domiciliary jurisdiction of the counterparty is either in the United States or in a foreign jurisdiction listed in the Purposes and Procedures Manual of the Securities Valuation Office as eligible for netting.

(c) For purposes of this Section, the market value or the net sum payable, as applicable, is determined at the end of the most recent quarter of the insurer's fiscal year and is reduced by the market value of acceptable collateral held by the insurer or a custodian on the insurer's behalf.

(2) "Derivative instrument" means an agreement, option or instrument, or any series or combination thereof, to make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or instead to make a cash settlement, or that has a price, yield, level, performance, value, or cash flow which is based primarily on that of one or more underlying interests. The term includes options (calls and puts), a warrant not otherwise permitted to be held by the insurer under this Section, a cap, a floor, a collar, a swap, a swaption, a forward, a future, and any other substantially similar instruments. The term does not include a collateralized mortgage obligation, another asset-backed security, a principal-protected structured security, a floating rate security, an instrument that an insurer is otherwise permitted to invest in or receive under this Section other than under this definition, or any debt obligation of the insurer.

(3) "Market value" means the price for a security or derivative obtained from a generally recognized source or the most recent quotation from such a source or, if a generally recognized source does not exist, the price for the security or derivative instrument as determined under the terms of the instrument or in good faith by the insurer, as can be reasonably demonstrated to the commissioner on request, plus accrued but unpaid income on the security or derivative instrument to the extent not included in the price as of the applicable date.

(4) "Potential exposure" means:

(a) As to a futures position, the amount of the initial margin required for that position.

(b) As to swaps, swaptions, collars, and forwards, one-half percent times the notional amount times the square root of the remaining years to maturity.

(5) "Replication transaction" means a derivative transaction or combination of derivative transactions affected either separately or in conjunction with cash market investments included in the insurer's investment portfolio to replicate the risks and returns of another authorized transaction, investment, or instrument or to operate as a substitute for a cash market transaction. The term does not include a derivative transaction entered into by the insurer as a hedging transaction.

B. An insurer may engage in derivative transactions under this Section under the following general conditions:

(1) An insurer may use derivative instruments under this Section to engage in hedging transactions and income generation transactions.

(2) An insurer may use derivative instruments only if prior thereto the board of directors of such insurer has adopted a written policy and has filed the policy with the commissioner of insurance specifying the following:

(a) The types of risk-limiting practices and income-generating transactions approved for such insurer.

(b) The aggregate maximum limits in such instruments, which maximum limits must be reasonably related to the insurer's business needs and its capacity to fulfill its obligations thereunder.

(c) The specific assets or class of assets or cash flows for which risk-limiting practices may be employed.

(d) The insurer's accounting or investment records shall specifically identify the assets or cash flows for which each risk-limiting practice is used.

(3) All transactions in derivative instruments shall be authorized or approved by the insurer's board of directors or by a committee authorized by such board and charged with the supervision or making of such transactions. The minutes of any such committee shall be recorded and regular reports of the committee shall be submitted to the board of directors.

(4) With respect to all hedging transactions, an insurer shall be able to demonstrate to the commissioner the intended hedging characteristics and the ongoing effectiveness of the derivative transaction or combination of the transactions through cash-flow testing or other appropriate analyses.

(5) The counterparty must have a quality rating of NAIC 1.

(6) The commissioner may adopt reasonable rules for investments and transactions under this Section, including but not limited to rules which impose financial solvency standards, valuation standards, and reporting requirements.

C. An insurer may enter into hedging transactions under this Section if, as a result of and after giving effect to the transaction:

(1) The aggregate statement value of options, caps, floors, and warrants not attached to another financial instrument purchased and used in hedging transactions then engaged in by the insurer does not exceed the lesser of thirty percent of its surplus and three percent of its admitted assets.

(2) The aggregate statement value of options, caps, and floors written or sold in hedging transactions then engaged in by the insurer does not exceed the lesser of ten percent of its surplus and one percent of its admitted assets.

(3) The aggregate potential exposure of collars, swaps, swaptions, forwards, and futures used in hedging transactions then engaged in by the insurer does not exceed the lesser of twenty percent of its surplus and two percent of its admitted assets.

(4) The limitations specified in this Subsection can be exceeded if the insurer obtains prior approval from the commissioner.

D.(1) An insurer may enter into the following types of income-generating transactions subject to the quantitative limits of Paragraph (2) of this Subsection:

(a) Sales of covered call options on noncallable fixed income securities, callable fixed income securities if the option expires by its terms prior to the end of the noncallable period, or derivative instruments based on fixed income securities.

(b) Sales of covered call options on equity securities, if the insurer holds in its portfolio or can immediately acquire through the exercise of options, warrants, or conversion rights already owned, the equity securities subject to call during the complete term of the call option sold.

(c) Sales of covered puts on investments that the insurer is permitted to acquire under this Section, if the insurer has escrowed, or entered into a custodian agreement segregating, cash or cash equivalents with a market value equal to the amount of the purchase obligations under the put during the complete term of the put option sold.

(d) Sales of covered caps or floors, if the insurer holds in its portfolio the investments generating the cash flow to make the required payments under the caps or floors during the complete term that the cap or floor is outstanding.

(2) If as a result of and after giving effect to the transactions, the aggregate statement value of the fixed income assets that are subject to call or that generate the cash flow for payments under the caps or floors, plus the face value of fixed-income securities underlying a derivative instrument subject to call, plus the amount of the purchase obligations under the puts, shall not exceed the lesser of fifty percent of its surplus and five percent of its admitted assets.

E.(1) An insurer may enter into a replication transaction only with the prior written approval of the commissioner. To be eligible for approval by the commissioner:

(a) The insurer must be otherwise authorized to invest its funds under this Part in the asset being replicated; and

(b) Any asset being replicated is subject to all the provisions and limitations on the making thereof specified in this Section with respect to investments by the insurer as if the transaction constituted a direct investment by the insurer in the replicated asset.

(2) The commissioner may adopt rules regarding replication transactions as necessary to implement this Subsection.

F.(1) Before engaging in a transaction authorized under this Section, an insurer that has a statutory net capital and surplus of less than ten million dollars shall file a written notice with the commissioner describing the need to engage in the transaction, the lack of acceptable alternatives, and the insurer's plan to engage in the transaction. If the commissioner does not issue an order prohibiting the insurer from engaging in the transaction within ninety days after the date of receipt of the insurer's notice, the insurer may engage in the transaction described in the notice.

(2) An insurer that has a statutory net capital and surplus of ten million dollars or greater shall file a written notice with the commissioner describing the need to engage in the transaction and the lack of acceptable alternatives within ninety days of initiating the transaction.

(3) The commissioner may at any time issue an order prohibiting an insurer or insurers from engaging in transactions otherwise authorized under this Section, if the transactions are deemed likely to subject the insurance company to a hazardous financial condition.

(4) An insurer with a statutory net capital and surplus less than the minimum amount of capital and surplus required for a new charter and certificate of authority for the same type of insurer may not engage in the transactions authorized under this Section.

G. The commissioner of insurance may adopt regulations to implement the provisions of this Section.

Acts 2001, No. 61, §1.

§844.3. Loaning of securities

A. A domestic insurer may lend securities held by it to any member of the National Association of Securities Dealers having a net worth of at least one hundred million dollars, under this Part, if:

(1) Simultaneously with the delivery of the securities, the insurer receives from the borrower collateral consisting of cash or of securities issued, assumed, or guaranteed by the United States, by any agency of the United States, or by any state having a present market value including accrued interest of not less than one hundred two percent of the then market value of the securities loaned.

(2) The securities are loaned only for the purpose of making delivery of securities in the case of short sales, in the case of failure to receive securities requested for delivery, or in other similar cases.

(3) The borrower furnishes the insurer, or a custodian of the insurer, prior to the loan the most recent statement of the borrower's financial condition and a representation by the borrower that there has been no material adverse change in its financial condition since the date of that statement.

(4) The insurer receives a reasonable fee related to the value of the borrowed securities and to the duration of the loan.

(5) The loan is made pursuant to a written loan agreement.

(6) The borrower is required to furnish by the close of each business day during the term of the loan a report of the market value of all collateral and the market value of all borrowed securities as of the close of trading on the previous business day. If at the close of any business day the market value of the collateral is less than one hundred two percent of the market value of the securities loan, then the borrower is required to deliver by the close of the next business day an additional amount of cash or securities, the market value of which, together with the market value of all previously delivered collateral, equals at least one hundred two percent of the market value of the securities loaned. Securities on loan that clear through the Federal Reserve System shall be marked to market when the collateral level is less than one hundred percent. At that time, a one hundred two percent margin shall be reestablished by close of the next business day.

B. Securities used for collateral in this Section must not be in default, and the entity which issued, assumed, or guaranteed the security shall not be in default in the payment of its debt securities, either principal or interest, while the securities are used as collateral for securities loaned.

Acts 1984, No. 591, §1; Acts 2003, No. 126, §1.

§845. Restriction on acquisition and holding of real property

A. No domestic insurer may acquire or hold real property except as follows:

(1) Such as shall be requisite for the convenient accommodation of the transaction of its own business; the amount invested in such real property shall not exceed twenty per cent of the investing insurer's admitted assets, but the commissioner of insurance may grant permission to the insurer to invest in real property for such purpose, in such increased amount as he may deem proper on the showing made if, upon a hearing held before him, he shall find that the amount represented by such percentage of its admitted assets is insufficient to provide convenient accommodation for the insurer's business;

(2) Such as shall have been mortgaged to it in good faith by way of security for loans previously contracted or for monies due;

(3) Such as shall have been conveyed to it in satisfaction of debts previously contracted in course of its dealings;

(4) Such as shall have been purchased at sales on judgments, decrees or mortgages obtained or made for such debts; and

(5) Such unencumbered real property as shall have been acquired, in whole or in part, in exchange for real property of approximately the same value theretofore legally acquired and held by it, provided that the amount invested in any one parcel of property so acquired, other than property acquired for the purpose, specified in paragraph (1), shall not exceed two per cent of the investing insurer's admitted assets.

(6) Such real estate as shall have been acquired in R.S. 22:844.

(7) Such as shall be held as security for contracts for deeds acquired in accordance with the provisions of R.S. 22:844A(5), and not in default.

(8) Such as may be acquired or held in connection with a loan or investment permitted by R.S. 22:844(H).

B. All real property acquired for purposes, or in the manner, specified in paragraphs other than paragraphs (1), (6), (7), and (8) of Subsection A may be held for a period of five years after the insurer shall have acquired title to the same and thereafter until the date specified in an order issued by the commissioner of insurance directing the insurer to dispose of the same. The date specified in such order shall be not less than six months from the date of the service of the said order upon the insurer. No such order shall be issued without a hearing and a determination by the commissioner of insurance that the interests of the insurer will not suffer materially by the sale of the same within the period to be specified.

Acts 1958, No. 125.

§846. Foreign securities

A. An insurer authorized to transact insurance in a foreign country may invest any of its funds, in an aggregate amount not exceeding one hundred twenty per cent of its reserves and other statutory obligations incurred in such country, or such greater amount as it may be required by law to invest in such country, and maintain the same there, in securities of such country possessing characteristics and of a quality similar to those required pursuant to this Part for investments in the United States; provided that, if an insurer shall show, to the satisfaction of the commissioner of insurance, that it is impossible to withdraw from a foreign country, or that the interest of the insurer will suffer materially by such withdrawal, any of its funds in excess of the limit imposed in this Section, such insurer shall not be deemed to be in violation of the provisions hereof.

B. An insurer may invest any of its funds, in an aggregate amount not exceeding five per cent of its assets, in addition to any amount permitted pursuant to Sub-section A of this Section, in obligations of the government of the Dominion of Canada or of Canadian provinces or municipalities, and in obligations of Canadian corporations, which have not been in default during the five years next preceding date of acquisition, and which are otherwise of equal quality to like United States public or corporate securities as prescribed in this Part.

C. In addition to the investments authorized in Subsections A and B of this Section, an insurer authorized to transact insurance in a foreign country may invest an amount or amounts in the aggregate not exceeding thirty percent of its capital and surplus if a stock company, or thirty percent of its surplus if a mutual company, in such investments as are allowed in R.S. 22:844 in a foreign country with which the United States has diplomatic relations or had diplomatic relations on January 1, 1978. For the purposes of investments made under this Subsection, all references to the United States appearing in R.S. 22:844 shall be considered to name the particular foreign country or countries in which the investments made hereunder are placed.

Acts 1958, No. 125. Amended by Acts 1977, No. 205, §1. Acts 1983, No. 353, §1; Acts 1997, No. 988, §1.

§847. When restrictions not applicable

A. The restrictions of R.S. 22:844 and 22:845 shall not apply to securities or other assets acquired through merger or consolidation with any other insurer or through a reinsurance agreement, if such assets when originally acquired constituted legal investments for the merged, consolidated or ceding insurer which acquired them, nor shall such provisions apply to securities, obligations or other assets accepted incident to the adjustment or realization of any debt or investment when deemed by the board of directors or investment committee to be in the best interests of the insurer, but, subject to the provisions of Sub-section B all such securities, obligations or other assets so acquired or accepted after 12:00 noon of October 1, 1948, which are not in accordance with the provisions of this Part shall be disposed o f not later than five years after the date of such acquisition or acceptance, or if acquired prior to 12:00 noon of October 1, 1948, not later than five years after such latter date.

B. The commissioner of insurance, upon application by the insurer, may extend the time for the disposition of such securities, obligations or other assets for such period or periods as he may deem proper on the showing made, if such insurer may suffer materially by the forced sale thereof; and the commissioner of insurance shall grant a hearing to the insurer upon request.

Acts 1958, No. 125.

§848. Excessive commissions prohibited; interest of officers and directors

A. No domestic insurer shall pay any commission or brokerage for the purchase or sale of property in excess of that usual and customary at the time and in the locality where such purchases or sales are made, and information regarding all payments of commissions and brokerage shall be reported in the next annual statement.

B. No such insurer shall invest in or loan upon any real estate which is owned or partly owned by any officer or director of such insurer, nor shall any such insurer invest in or loan upon any bond or note secured by mortgage or trust deed on real estate if an officer or director of such insurer is owner or part owner of the real estate upon which the loan is made.

C. Any officer or director knowingly participating in or abetting the violation of any provision of this Section where fraud is shown to exist shall be fined not less than one thousand dollars nor more than ten thousand dollars or imprisoned not more than ten years, or both.

Acts 1958, No. 125.

§849. Authorization of investments

No investment, loan, sale or exchange thereof shall, except as to the policy loans of a life insurer, be made by any domestic insurer unless authorized or approved by its board of directors or by a committee thereof or by a director authorized by such committee or charged by the board of directors or by the by-laws with the duty of making such investments, loan, sale or exchange. The minutes of any such committee shall be recorded and reports thereof shall be submitted to the board of directors for approval or disapproval.

Acts 1958, No. 125.

§850. Record of investments

A. As to each investment or loan of the funds of a domestic insurer a written authorization thereof in permanent form shall be made, and signed by the officer or chairman of such committee authorizing the investment or loan.

B. As to each such investment or loan the insurer's records shall contain:

(1) In the case of loans: The name of the borrower; the location and legal description of the property; a physical description, and the appraised value of the security; the amount of the loan, rate of interest and terms of repayment.

(2) In the case of securities: The name of the obligor; a description of the security, the amount invested, the rate of interest or dividend, the maturity and yield based upon the purchase price.

(3) In the case of real estate: The location and legal description of the property; a physical description and the appraised value; the purchase price and terms.

(4) In the case of all investments:

(a) The amount of expenses estimated, if details not available and commissions if any incurred on account of any investment or loan and by whom and to whom payable if not covered by contracts with mortgage loan representatives or correspondents which are part of the insurer's records;

(b) The name of any officer or director of the insurer having any direct, indirect, or contingent interest in the securities or loan representing the investment, or in the assets of the person in whose behalf the investment or loan is made, and the nature of such interest.

Acts 1958, No. 125.

§851. Investments of foreign, alien insurers

The investments of a foreign or alien insurer shall be as permitted by the laws of its domicile but shall be of a quality substantially as high as those required under this Part for similar funds of like domestic insurers.

Acts 1958, No. 125.

§852. When investments must comply

The investments in securities and real estate of all domestic insurers shall be made to conform to the requirements of this Part by not later than 12:00 noon of October 1, 1953, but the commissioner of insurance may, on application by the insurer, extend the time for such conformance for such period or periods as he may deem proper on the showing made, if he is satisfied that such insurer will suffer materially by the forced sale of any securities or property not conforming; and the commissioner of insurance shall grant a hearing to the insurer upon request.

Acts 1958, No. 125.

§853. Acquisition and holding of real property by domestic insurers in foreign countries

An insurer authorized to transact insurance in a foreign country may acquire and hold real property such as shall be requisite for the convenient accommodation of the transacting of its own business in any such country and such property may include additional space to be rented or leased to third parties for the purpose of producing income to help defray the cost of acquisition, construction, and maintenance of the building, as well as a return on the investment in addition to that derived from the company's own use of a portion of the property. The investment in such a building shall not exceed ten per cent of the company's assets in such country and must be built from funds arising from the transaction of business in such country.

Such property shall be considered as a foreign security within the meaning of R.S. 22:846. The investment in such property shall also be included, together with that of other real estate held under the terms of R.S. 22:845 in determining whether or not there has been compliance with the limit on investments fixed by R.S. 22:845 A.(1).

Acts 1958, No. 125.

§854. Pledging of assets restricted; penalties

A. It shall be unlawful for any insurance company domiciled in this state to pledge its assets solely to secure a personal loan, other than a policy loan based on the contractual terms of a policy of insurance issued by the company, if the loan is solely for the personal benefit of any officer, director, or employee. Nothing herein shall be construed to limit the right of an insurance company to pledge any or all of its assets to secure loans in the ordinary course of its business and for the company's business purposes and to obtain, as further security therefor, the guarantee, personal or otherwise, of any officer, director, or employee. The commissioner may bring an action to recover and conserve any asset pledged in violation of this Section.

B. Any company or any officer, director, or employee violating this Section may be fined not more than ten thousand dollars for each violation, and the officer, director, or employee may be removed from such office, position, capacity, or relationship with the company.

Acts 1987, No. 311, §1.

§855. Admitted assets

For the purposes of this Part, the following assets, if owned by an insurer, shall be known as admitted assets:

(1) Cash in the possession of the insurer or in transit under its control, and including the true balance of any deposit in a solvent bank or trust company.

(2) Investments, securities, properties, and loans acquired, or held, in accordance with this Part and in connection therewith the following items:

(a) Interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest.

(b) Declared and unpaid dividends on stock and shares, unless such amount has otherwise been allowed as an asset.

(c) Interest due or accrued upon a collateral loan in an amount not to exceed one year's interest thereon.

(d) Interest due or accrued on deposits in solvent banks and trust companies, and interest due or accrued on other assets, if such interest is in the judgment of the commissioner a collectible asset.

(e) Interest due or accrued on a mortgage loan, in an amount not exceeding in any event the amount, if any, of the excess of the value of the property less delinquent taxes thereon over the unpaid principal; but in no event shall interest accrued for a period in excess of twelve months be allowed as an asset.

(f) Rent due or accrued on real property, if such rent is not in arrears for more than three months, and rent more than three months in arrears, if the payment of such rent is adequately secured by property held in the name of the tenant and conveyed to the insurer as collateral.

(g) The unaccrued portion of taxes paid prior to the due date on real property.

(3) Premium notes, except as specifically excluded by R.S. 22:856(7), policy loans and other policy assets and liens on policies and certificates of life insurance and annuity contracts, and accrued interest thereon, in an amount not exceeding the legal reserve and other policy liabilities carried on each individual policy.

(4) The net amount of uncollected and deferred premiums and annuity considerations in the case of a life insurer.

(5) Premiums in the course of collection, other than for life insurance, not more than three months due, less commissions payable thereon. The foregoing limitation shall not apply to premiums payable, directly or indirectly, by the United States government or by any of its instrumentalities.

(6) Installment premiums, other than life insurance premiums, to the extent of the unearned premium reserve carried on the policy to which premiums apply.

(7) Notes and life written obligations not past due taken for premiums, other than life insurance premiums, on policies permitted to be issued on such basis, to the extent of the unearned premium reserves carried thereon.

(8) The full amount of reinsurance recoverable by a ceding insurer from a solvent reinsurer and which reinsurance is authorized under the Louisiana Insurance Code.

(9) Amounts receivable by an assuming insurer representing funds withheld by a solvent ceding insurer under a reinsurance agreement.

(10) Deposits or equities recoverable from underwriting associations, syndicates and reinsurance funds, or from any suspended banking institution, to the extent deemed by the commissioner, available for the payment of losses and claims and at values to be determined by him.

(11) Electronic and mechanical machines constituting a data processing and accounting system, if the cost of such system is at least ten thousand dollars, which costs shall be amortized in full over a period not to exceed ten calendar years. The book value of the apparatus and equipment shall not exceed two percent of the admitted assets of the insurer.

(12) Other assets, not inconsistent with the provisions of this Section, deemed by the commissioner to be available for the payment of losses and claims, at values to be determined by him.

(13) Goodwill purchased by a domestic life insurance company possessing twice the required capital and surplus. Goodwill shall be the same as defined in the Purposes and Procedures Manual of the Securities Valuation Office of the National Association of Insurance Commissioners. Goodwill shall be amortized in accordance with the instructions set forth in the same manual, and amounts in excess of ten percent of an insurer's capital and surplus shall be written off immediately by a direct charge to surplus.

Acts 1992, No. 811, §1; Acts 1993, No. 787, §1; Acts 1995, No. 1124, §1; Acts 1997, No. 1449, §1.

§856. Excluded assets

In addition to assets impliedly excluded by the provisions of R.S. 22:855, the following expressly shall not be allowed as assets in any determination of the financial condition of an insurer:

(1) Goodwill, trade names, and other intangible assets, except as provided for pursuant to R.S. 22:855(13).

(2) Advances to officers, directors, and controlling stockholders, other than policy loans, unless the same are secured by collateral satisfactory to the commissioner, and advances to employees, agents, and other persons on personal security only.

(3) Stock of such insurer owned by it, or any equity therein, or loans secured thereby or any material proportionate interest in such stock acquired, or held, through the ownership by such insurer of an interest in another firm, corporation, or business unit.

(4) Furniture, fixtures, furnishings, safes, vehicles, libraries, stationery, literature, and supplies, except:

(a) Such personal property as is required through foreclosure of chattel mortgages under loans insured or guaranteed under provisions of the National Housing Act or any act of congress relating to veterans benefits.

(b) Such as is reasonably necessary for the maintenance and operation of real estate held by it other than real estate for home office, branch office, and similar purposes.

(c) In the case of title insurers, abstract plant and equipment not to exceed fifty percent of the paid-in capital stock of such title insurer.

(5) The amount, if any, by which the aggregate book value of investments, as carried in the assets of the insurer, exceeds the aggregate value, as determined under the provisions of the Louisiana Insurance Code.

(6) Rental assets, which for the purposes of this Section shall include but not be limited to the following:

(a) Any item carried as an asset on the insurer's balance sheet which is not, in fact, actually owned by the insurer.

(b) Any item carried as an asset on the insurer's balance sheet, the ownership of which is subject to resolution, recision, or revocation upon the insurer's insolvency, receivership, bankruptcy, statutory supervision, rehabilitation, liquidation, or upon the occurrence of any other contingency.

(c) Any item carried as an asset on the insurer's balance sheet for which the insurer pays a regular or periodic fee for the right to carry such items as an asset, whether or not such fee is characterized as a rental, a management fee, or an extraordinary dividend not previously approved by the commissioner of insurance, or other periodic payment for such right.

(d) Any asset purchased by the insurer on credit whereby the interest rate paid by the insurer on its credit instrument is greater than the interest rate or yield generated by the purchased asset.

(e) Any item carried by the insurer as an asset on its balance sheet which is subject to a mortgage, lien, privilege, preference, pledge, charge, or other encumbrance which is not accurately reflected on the liability section of the company's balance sheet.

(f) Any asset received by the company as a contribution to capital from any affiliate, holding company, or control person, or from any affiliate of any such affiliate, holding company, or control person, which meets any of the criteria set forth in Subparagraphs (a) through (e) above while in the hands of such contributing party, or at the moment of such contribution to capital, or thereafter.

(7) Premium notes on policies and certificates of life insurance and annuity contracts, and accrued interest thereon, except when the insurer, issuer, or noteholder agrees to an examination by the department to determine whether any inflation or duplication of assets exists.

Acts 1992, No. 811, §1; Acts 1993, No. 787, §1; Acts 1995, No. 1124, §1; Acts 1997, No. 1449, §1.

§857. Valuation of investments

A. All securities owned by a domestic insurance company shall be valued in accordance with the standards promulgated by the Securities Valuation Office of the National Association of Insurance Commissioners.

B. Any other invested assets of domestic insurers shall be valued in accordance with procedures promulgated by the financial condition subcommittee of the National Association of Insurance Commissioners.

Acts 1992, No. 811, §1.

§858. Insurer investment pools

A. For purposes of this Section:

(1) "Affiliate" means, as to any person, another person that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person.

(2) "Business entity" means a corporation, limited liability company, association, partnership, joint stock company, joint venture, mutual fund, trust, joint tenancy, or other similar form of business organization, whether organized for-profit or not-for-profit.

(3) "Class one money market mutual fund" means a money market fund that at all times qualifies for investment using the bond class one reserve factor under the Purposes and Procedures of the Securities Valuation Office of the National Association of Insurance Commissioners, or any successor publication.

(4) "Government money market mutual fund" means a money market mutual fund that complies with all of the following requirements:

(a) Invests only in obligations issued, guaranteed, or insured by the federal government of the United States or collateralized repurchase agreements composed of these obligations.

(b) Qualifies for investment without a reserve under the Purposes and Procedures of the Securities Valuation Office of the National Association of Insurance Commissioners, or any successor publication.

(5) "Money market mutual fund" means a mutual fund that meets the conditions of 17 Code of Federal Regulations Par. 270.2a-7, under the Investment Company Act of 1940 (15 U.S.C. 80-a-1 et seq.), as amended or renumbered.

(6) "Obligation" means a bond, note, debenture, trust certificate, including equipment certificate, production payment, negotiable bank certificate of deposit, bankers' acceptance, credit tenant loan, loan secured by financing net leases and other evidence of indebtedness for the payment of money or participations, certificates or other evidences of an interest in any of the foregoing, whether constituting a general obligation of the issuer or payable only out of certain revenues or certain funds pledged or otherwise dedicated for payment.

(7) "Qualified bank" means a national bank, state bank, or trust company that at all times is no less than adequately capitalized as determined by the standards adopted by the United States banking regulators and that is either regulated by state banking laws or is a member of the Federal Reserve System.

(8) "Repurchase transaction" means a transaction in which an insurer purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the insurer at a specified price, either within a specified period of time or upon demand.

(9) "Reverse repurchase transaction" means a transaction in which an insurer sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period of time or upon demand.

(10) "Securities lending transaction" means a transaction in which securities are loaned by an insurer to a business entity that is obligated to return the loaned securities or equivalent securities to the insurer, either within a specified period of time or upon demand.

(11) "SVO" means the Securities Valuation Office of the National Association of Insurance Commissioners.

B. An insurer may acquire investments in investment pools that:

(1) Invest only in the following:

(a) Obligations that are rated one or two by the SVO or have an equivalent of an SVO one or two rating, or in the absence of a one or two rating or equivalent rating the issuer has outstanding obligations with an SVO one or two or equivalent rating, as rated by a nationally recognized statistical rating organization recognized by the SVO and have:

(i) A remaining maturity of three hundred ninety-seven days or less or a put that entitles the holder to receive the principal amount of the obligation which put may be exercised through maturity at specified intervals not exceeding three hundred ninety-seven days.

(ii) A remaining maturity of three years or less and a floating interest rate that resets no less frequently than quarterly on the basis of a current short-term index, such as federal funds, prime rate, treasury bills, London InterBank Offered Rate, or commercial paper, and is subject to no maximum limit, if the obligations do not have an interest rate that varies inversely to market interest rate changes.

(b) Government money market mutual funds or class one money market mutual funds.

(c) Securities lending, repurchase, and reverse repurchase transactions that meet all the requirements of R.S. 22:844(I) and 844.3.

(2) Invest only in investments which an insurer may acquire under this Part, if the insurer's proportionate interest in the amount invested in these investments does not exceed the applicable limit of this Title.

C. For an investment in an investment pool to be qualified under this Part, the investment pool shall not:

(1) Acquire securities issued, assumed, guaranteed or insured by the insurer or an affiliate of the insurer.

(2) Borrow or incur any indebtedness for borrowed money, except for securities lending and reverse repurchase transactions that meet the requirements of this Part.

(3) Permit the aggregate value of securities then loaned or sold to, purchased from, or invested in any one business entity under this Section to exceed ten percent of the total assets of the investment pool.

D. The limitations of R.S. 22:844 shall not apply to an insurer's investment in an investment pool, however, an insurer shall not acquire an investment in an investment pool under this Section if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this Section:

(1) In any one investment pool would exceed ten percent of its admitted assets.

(2) In all investment pools investing in investments permitted under Paragraph B(2) of this Section would exceed twenty-five percent of its admitted assets.

(3) In all investment pools would exceed thirty-five percent of its admitted assets.

E. For an investment in an investment pool to be qualified under this Section, the manager of the investment pool shall:

(1) Be organized under the laws of the United States or a state and designated as the pool manager in a pooling agreement.

(2) Be the insurer, an affiliated insurer or a business entity affiliated with the insurer, a qualified bank, a business entity registered under the Investment Advisors Act of 1940 (15 U.S.C. 80A-1 et seq.), as amended or, in the case of a reciprocal insurer or interinsurance exchange, its attorney-in-fact, or in the case of a United States branch of an alien insurer, its United States manager or affiliates or subsidiaries of its United States manager.

(3) Compile and maintain detailed accounting records setting forth:

(a) The cash receipts and disbursements reflecting each participant's proportionate investment in the investment pool.

(b) A complete description of all underlying assets of the investment pool including amount, interest rate, maturity date, if any, and other appropriate designations.

(c) Other records which, on a daily basis, allow third parties to verify each participant's investment in the investment pool.

(4) Maintain the assets of the investment pool in one or more accounts, in the name of or on behalf of the investment pool, under a custody agreement with a qualified bank. The custody agreement shall:

(a) State and recognize the claims and rights of each participant.

(b) Acknowledge that the underlying assets of the investment pool are held solely for the benefit of each participant in proportion to the aggregate amount of its investments in the investment pool.

(c) Contain an agreement that the underlying assets of the investment pool shall not be commingled with the general assets of the custodian qualified bank or any other person.

F. The pooling agreement for each investment pool shall be in writing and shall provide that:

(1) An insurer and its affiliated insurers or, in the case of an investment pool investing solely in investments permitted under Paragraph B(1) of this Section, the insurer and its subsidiaries, affiliates, or, in the case of a United States branch of an alien insurer, affiliates or subsidiaries of its United States manager, shall at all times, hold one hundred percent of the interests in the investment pool.

(2) The underlying assets of the investment pool shall not be commingled with the general assets of the pool manager or any other person.

(3) In proportion to the aggregate amount of each pool participant's interest in the investment pool:

(a) Each participant owns an undivided interest in the underlying assets of the investment pool.

(b) The underlying assets of the investment pool are held solely for the benefit of each participant.

(4) A participant may withdraw all or any portion of its investment from the pool under the terms of the pooling agreement. In the event of the participant's insolvency, bankruptcy or receivership, its trustee, receiver, or other successor-in-interest shall have the authority to withdraw all of the investment from the pool. The investment shall be considered an asset pursuant to R.S. 22:755.

(5) Withdrawals may be made on demand without penalty or other assessment on any business day, but settlement of funds shall occur within a reasonable and customary period thereafter not to exceed five business days. Distributions under this Paragraph shall be calculated in each case net of all then applicable fees and expenses of the investment pool. The pooling agreement shall provide that the pool manager shall distribute to a participant, at the discretion of the pool manager:

(a) In cash, the then fair market value of the participant's pro rata share of each underlying asset of the investment pool.

(b) In kind, a pro rata share of each underlying asset.

(c) In a combination of cash and in kind distributions, a pro rata share in each underlying asset.

(6) The pool manager shall make the records of the investment pool available for inspection by the commissioner.

G. The investment pool authorized under this Section shall be a business entity.

H. Transactions between the pool and its participants shall not be subject to R.S. 22:1006(A)(6). Investment activities of pools and transactions between pools and participants shall be reported annually in the registration statement required by R.S. 22:1005.

Acts 1997, No. 1171, §1.

PART XVIII-A. RISK-BASED CAPITAL FOR DOMESTIC INSURERS

§860. Definitions

As used in this Part, the following terms shall have the following meanings:

(1) "Adjusted risk-based report" means a risk-based capital report which has been adjusted by the department in accordance with R.S. 22:861(C).

(2) "Corrective order" means an order issued by the department specifying corrective actions which are required.

(3) "Life or health and accident insurer" means any insurance company possessing a certificate of authority in the state that issues the kind of insurance listed in R.S. 22:6(1) or (2) or a property and casualty insurer possessing a certificate of authority in the state that issues only health and accident insurance as specified in R.S. 22:6(2).

(4) "NAIC" means the National Association of Insurance Departments.

(5) "Negative trend" shall have that meaning, with respect to a life and/or health insurer, as determined in accordance with the trend test calculation included in the risk-based capital instructions.

(6) "Property and casualty insurer" means any insurance company possessing a certificate of authority in the state that issues insurance other than the kinds specified in R.S. 22:6(1), (2), and (9).

(7) "Risk-based capital instructions" means the risk-based capital report including risk-based capital instructions adopted by the NAIC, as such risk-based capital instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(8) "Risk-based capital level" means an action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital, or mandatory control level risk-based capital of an insurer where:

(a) "Authorized-control level risk-based capital" means the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

(b) "Company-action level risk-based capital" means the product of two multiplied by its authorized control level risk-based capital.

(c) "Mandatory-control level risk-based capital" means seven-tenths multiplied by the authorized control level risk-based capital.

(d) "Regulatory-action level risk-based capital" means one and one-half multiplied by the authorized control level risk-based capital.

(9) "Risk-based capital plan" means a comprehensive financial plan containing the requirements of R.S. 22:862(B). If the department rejects a risk-based capital plan, and it is revised by the insurer, with or without the recommendation of the department, the plan shall be designated a revised risk-based capital plan.

(10) "Risk-based capital report" means the report required pursuant to R.S. 22:861.

(11) "Total adjusted capital" means the sum of:

(a) An insurer's statutory capital and surplus.

(b) Such other items, if any, as required by R.S. 22:860(7).

Acts 1995, No. 1203, §1, eff. June 29, 1995.

§861. Reports; risk-based capital

A. Unless it appears in the discretion of the commissioner that the condition of a small company renders the continuance of its business hazardous to the public or its insureds, a small company shall not be required to submit to the department a risk-based capital report required by this Section. Every other domestic insurer shall submit to the department on or prior to March first of each year a report of its risk-based capital levels as of the end of the prior calendar year, in a form that contains information required by the risk-based capital instructions. In addition, every other domestic insurer shall file the risk-based capital report:

(1) With the NAIC in accordance with the risk-based capital instructions.

(2) With the insurance department in any state in which the insurer is authorized to do business, if required by the department.

(a) No later than fifteen days from the receipt of notice to file its risk-based capital report with that state.

(b) By March first of each year.

B. The risk-based capital of a life and health and accident insurer shall be determined in accordance with a formula of the risk-based capital instructions. The formula shall take into account and may adjust for the covariance between:

(1) The risk with respect to the insurer's assets.

(2) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations.

(3) The interest rate risk with respect to the insurer's business.

(4) All other business risks and such other relevant risks as are set forth in the risk-based capital instructions.

C. The risk-based capital of a property and casualty insurer shall be determined in accordance with a formula of the risk-based capital instructions. The formula shall take into account and may adjust for the covariance between asset risk, credit risk, underwriting risk, and other business risks, as established in the risk-based capital instructions, as determined by the application of factors established in the risk-based capital instructions.

D.(1) If a domestic insurer files a risk-based capital report which in the determination of the Department of Insurance is inaccurate, the department shall adjust the risk-based capital report to correct the inaccuracy.

(2) The department shall notify the insurer of the adjustment.

(3) The notice shall contain a statement of the reason for the adjustment.

(4) A risk-based capital report so adjusted is referred to as an "adjusted risk-based capital report".

Acts 1995, No. 1203, §1, eff. June 29, 1995; Acts 1999, No. 1304, §1, eff. July 12, 1999; Acts 1999, No. 1312, §1, eff. July 12, 1999.

§862. Company-action level event

A. "Company-action level event" means any of the following events:

(1) The filing of a risk-based capital report by an insurer that indicates that:

(a) The total adjusted capital of the insurer is greater than or equal to its regulatory-action level risk-based capital, but less than its company-action level risk-based capital.

(b) The life or health and accident insurer maintains a total adjusted capital which is greater than or equal to its company-action level risk-based capital, but less than the product of its authorized-control level risk-based capital and two and one-half but has a negative trend.

(2) The notification of a domestic insurer by the department of an adjusted risk-based capital report which indicates an event under Paragraph B(1) of this Section unless the insurer fails to dispute the adjusted risk-based capital report required by R.S. 22:866.

(3) If a domestic insurer disputes an adjusted risk-based capital report and notification by the department to the insurer that the department has rejected the dispute after an administrative hearing.

B. In the event a company-action event occurs, the insurer shall prepare and submit to the department a risk-based capital plan that shall:

(1) Identify the conditions which contribute to the company action level event.

(2) Contain proposals of corrective actions which the insurer intends and which would be expected to result in the elimination of the company-action level event.

(3) Provide projections of the financial results of the insurer in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, or surplus. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each income, expense, and benefit component.

(4) Identify the key assumptions impacting the projections of the insurer and the sensitivity of the projections to those assumptions.

(5) Identify the quality and problems with the business of the insurer including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mixture of business, and use of reinsurance, if applicable.

C. The risk-based capital plan shall be submitted:

(1) Within forty-five days of the company-action level event.

(2) Within forty-five days after notification to the insurer that the department has rejected the dispute by an insurer after an administrative hearing.

D.(1) Within forty-five days after the submission by an insurer of a risk-based capital plan to the department, the department shall notify the insurer whether the risk-based capital plan shall be implemented or determined to be unsatisfactory by the department.

(2) If the department determines the risk-based capital plan is unsatisfactory, the notification to the insurer shall state the reasons for the unsatisfactory determination and set forth proposed revisions to render the risk-based capital plan satisfactory.

(3) Upon notification from the department, the insurer shall prepare a revised risk-based capital plan that may incorporate any revisions proposed by the department. The insurer shall submit the revised risk-based capital plan to the department:

(a) Within forty-five days after the notification from the department, unless otherwise disputed by the insurer.

(b) Within forty-five days after a notification to the insurer that the department has rejected the dispute of the insurer after an administrative hearing.

E. In the event of a notification by the department to an insurer that the risk-based capital plan is unsatisfactory, the department may state in the notification that the notification constitutes a regulatory-action level event, unless an administrative hearing is requested under R.S. 22:866.

F.(1) Every domestic insurer that files a risk-based capital plan or revised risk-based capital plan with the department shall file a copy of the risk-based capital plan or revised risk-based capital plan with the insurance department in any state in which the insurer is authorized to do business if:

(a) The state has a risk-based capital provision substantially similar to R.S. 22:867(A).

(b) The insurance department of that state has notified the insurer of its request for the filing in writing.

(2) The insurer shall file a copy of the risk-based capital plan or revised risk-based capital plan in that state no later than:

(a) Fifteen days after the receipt of notice to file a copy of its risk-based capital plan or revised risk-based capital plan with the state.

(b) The date on which the risk-based capital plan or revised risk-based capital plan is filed pursuant to Subsections C and D of this Section.

Acts 1995, No. 1203, §1, eff. June 29, 1995.

§863. Regulatory-action level event

A. "Regulatory-action level event" shall mean any of the following events:

(1) The filing of a risk-based capital report by the insurer which indicates that the total adjusted capital of the insurer is greater than or equal to its authorized control level risk-based capital but less than its regulatory-action level risk-based capital.

(2) The notification by the department to an insurer of an adjusted risk-based capital report that indicates the event in Paragraph (1) of this Subsection, unless challenged by the insurer pursuant to R.S. 22:866.

(3) The notification by the department to the insurer that the department has rejected the dispute by the insurer after an administrative hearing pursuant to R.S. 22:866.

(4) The failure of the insurer to file a risk-based capital report by March first of each year, unless the insurer has provided an explanation for such failure which is satisfactory to the department and has remedied the failure to file within ten days after March first of each year.

(5) The failure of the insurer to submit a risk-based capital plan to the department required in R.S. 22:862(C).

(6) The notification by the department to the insurer that:

(a) The department has determined the risk-based capital plan is unsatisfactory.

(b) Such notification constitutes a regulatory-action level event with respect to the insurer, unless the insurer disputes the action pursuant to R.S. 22:866.

(7) If the insurer disputes a determination of the department under Paragraph (6) of this Subsection, the notification by the department to the insurer that the dispute has been rejected by the department.

(8) The notification by the department that the insurer has failed to adhere to its risk-based capital plan or revised risk-based capital plan. The notification will occur if the failure has a substantial adverse effect on the ability of the insurer to eliminate the company-action level event in accordance with its risk-based capital plan or revised risk-based capital plan. The department shall state the adverse effect of the notification, unless the insurer failed to dispute the determination pursuant to R.S. 22:866.

(9) If the insurer challenges a determination by the department, the notification by the department in Paragraph (8) to the insurer that the department has rejected the dispute after an administrative hearing.

B. In the event of a regulatory-action level event, the department shall:

(1) Require the insurer to prepare and submit a risk-based capital plan or, if applicable, a revised risk-based capital plan to the department.

(2) Perform an examination or analysis as the department deems necessary of the assets, liabilities, and operations of the insurer including a review of its risk-based capital plan or revised risk-based capital plan.

(3) Subsequent to the examination or analysis, issue a corrective order.

C. The determination by the department for corrective action, may take into account such factors as are deemed relevant with respect to the insurer based upon the examination or analysis by the department of the assets, liabilities, and operations of the insurer. The analysis shall not be limited to the results of any sensitivity tests undertaken pursuant to the risk-based capital instructions. The risk-based capital plan or revised risk-based capital plan shall be submitted:

(1) Within forty-five days after the occurrence of the regulatory-action level event.

(2) Within forty-five days after the notification to the insurer that the department has rejected the dispute by the insurer after a hearing, unless the dispute is frivolous as determined by the department.

D. The department may retain actuaries, investment experts, and other consultants as may be necessary in the judgment of the department to review the risk-based capital plan or revised risk-based capital plan of the insurer, examine or analyze the assets, liabilities, and operations of the insurer and formulate the corrective order with respect to the insurer. The fees, reasonable costs, and expenses for the consultants shall be borne by the examined insurer or other party as directed by the department.

Acts 1995, No. 1203, §1, eff. June 29, 1995.

§864. Authorized-control level event

A. "Authorized-control level event" shall mean any of the following events:

(1) The filing of a risk-based capital report by the insurer which indicates that the total adjusted capital of the insurer is greater than or equal to its mandatory control level risk-based capital but less than its authorized-control level risk-based capital.

(2) The notification by the department to the insurer of an adjusted risk-based capital report that indicates the event in Paragraph (1) of this Subsection, unless the insurer disputes the adjusted risk-based capital report pursuant to R.S. 22:866.

(3) When the insurer challenges an adjusted risk-based capital report that indicates the event in Paragraph (1) of this Subsection, notification by the department to the insurer that the department has rejected the dispute by the insurer.

(4) The failure of the insurer to respond to a corrective order in a manner satisfactory to the department unless the insurer has disputed the corrective order pursuant to R.S. 22:866.

(5) If the insurer has disputed a corrective order pursuant to R.S. 22:866 and the department has rejected the dispute after an administrative hearing or modified the corrective order, the failure of the insurer to respond to the corrective order in a satisfactory manner subsequent to rejection or modification by the department.

B. In the event of an authorized-control level event by an insurer, the department shall:

(1) Take actions required pursuant to R.S. 22:863 against an insurer.

(2)(a) If the department deems it to be in the best interest of the policyholders, creditors of the insurer, and the public place the insurer under those proceedings provided by Part XVI of the Louisiana Insurance Code.

(b) In the event the department takes the actions permitted by this Section, the authorized-control level event shall be deemed sufficient grounds for the department to take action as provided by Part XVI of the Louisiana Insurance Code and to have the rights, powers, and duties with respect to the insurer as are set forth in Part XVI of the Louisiana Insurance Code.

(c) In the event the department takes any action under this Section based on an adjusted risk-based capital report, the insurer shall be entitled to such protection as provided in Part XVI of the Louisiana Insurance Code.

Acts 1995, No. 1203, §1, eff. June 29, 1995.

§865. Mandatory-control level event

A. "Mandatory-control level event" shall mean any of the following events:

(1) The filing of a risk-based capital report which indicates that the total adjusted capital of the insurer is less than the mandatory-control level risk-based capital.

(2) Notification by the department to the insurer of an adjusted risk-based capital report that indicates the event in Paragraph (1) of this Subsection, unless the insurer fails to dispute the adjusted risk-based capital report under R.S. 22:866.

(3) If the insurer disputes an adjusted risk-based capital report that contains the event in Paragraph (1) of this Subsection, notification by the department to the insurer that the department has rejected the dispute by the insurer after an administrative hearing.

B. In the event of a mandatory-control level event:

(1) For any domestic life insurer, the department shall take any actions necessary to place the insurer under regulatory control as provided by Part XVI of the Louisiana Insurance Code. The mandatory-control level event shall be deemed sufficient grounds for the department to place and maintain the rights, powers, and duties with respect to the insurer as are set forth in Part XVI of the Louisiana Insurance Code. If the department takes actions pursuant to an adjusted risk-based capital report, the insurer shall be entitled to the protection of the Louisiana Insurance Code. The department may forego action for up to ninety days after the mandatory-control level event if the department determines there is a reasonable expectation that the mandatory-control level event may be eliminated within the ninety-day period.

(2)(a) For any domestic property and casualty insurer, the department shall act as necessary to place the insurer under regulatory control as provided by Part XVI of the Louisiana Insurance Code, or, in the case of an insurer which is writing no business and which is running off of its existing business, may allow the insurer to continue its runoff under the administrative supervision of the department.

(b) The mandatory-control level event shall be deemed sufficient grounds for the department to place the insurer and maintain the rights, powers, and duties with respect to the insurer as are set forth in Part XVI of the Louisiana Insurance Code. If the department takes actions pursuant to an adjusted risk-based capital report, the insurer shall be entitled to the protection of the Louisiana Insurance Code pertaining to summary proceedings.

(c) The department may forego any action for up to ninety days after the mandatory-control level event if the department finds there is a reasonable expectation that the mandatory-control level event may be eliminated within the ninety-day period.

Acts 1995, No. 1203, §1, eff. June 29, 1995.

§866. Hearings; administrative

An insurer may make written demand for an administrative hearing, pursuant to the provisions of Part XXIX of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950, within thirty days after receipt of notification by the department of one of the following:

(1) Notification to an insurer by the department of an adjusted risk-based capital report.

(2) Notification to an insurer by the department that:

(a) The insurer's risk-based capital plan or revised risk-based capital plan is unsatisfactory.

(b) Such notification constitutes a regulatory-action level event with respect to such insurer.

(3) Notification to an insurer by the department that the insurer has failed to adhere to its risk-based capital plan or revised risk-based capital plan and that such failure has a substantial adverse effect on the ability of the insurer to eliminate the company-action level event with respect to the insurer in accordance with its risk-based capital plan or revised risk-based capital plan.

(4) Notification to an insurer by the department of a corrective order for the insurer.

Acts 1995, No. 1203, §1, eff. June 29, 1995.

§867. Confidentiality; prohibition on announcements, prohibition on use in ratemaking

A. All risk-based capital reports, to the extent the information is not set forth in a publicly available annual statement schedule and risk-based capital plans, including the results or report of any examination or analysis of an insurer performed pursuant to any corrective order issued by the department pursuant to examination or analysis, with respect to any domestic insurer or foreign insurer, which are filed with the department, constitute information that might be damaging to the insurer if made available to its competitors, and therefore shall be kept confidential by the department. The information shall not be made public or be subject to civil subpoena, other than by the department and then only for the purpose of enforcement actions taken by the department pursuant to this Part or any other provision of the Louisiana Insurance Code.

B. The total adjusted capital of an insurer to any of its risk-based capital level shall be a regulatory tool which may indicate the need for possible corrective action with respect to the insurer and shall not be intended as a means to rank insurers. The making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the risk-based capital levels of any insurer, or any component derived in the calculation by an insurer, agent, broker, or other person engaged in any manner in the insurance business may be misleading and prohibited. Except as otherwise required under the provisions of this Part, if any materially false statement about the total adjusted capital of an insurer or inappropriate comparison of any other amount of the risk-based capital level of an insurer is published in any written publication, the insurer, after due proof to the commissioner of insurance, may publish an announcement in any written publication solely to rebut the materially false statement.

C. The risk-based capital instructions, risk-based capital reports, adjusted risk-based capital reports, risk-based capital plans, and revised risk-based capital plans shall be intended solely for the use by the commissioner in monitoring the solvency of insurers. The need for possible corrective action with respect to insurers shall not be used by the commissioner for ratemaking or consideration or introduction for evidence in any rating procedure and shall not be used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which an insurer or any affiliate is authorized to write.

Acts 1995, No. 1203, §1, eff. June 29, 1995.

§868. Supplemental provisions; rules; exemption

A. The provisions of this Part are supplemental to any other provision of the laws of this state and shall not preclude or limit any other powers or duties of the department under the Louisiana Insurance Code.

B. The department may adopt reasonable rules and regulations necessary for the implementation of this Part.

C. The department may exempt from the application of this Part any domestic property and casualty insurer which:

(1) Writes direct business only in this state.

(2) Writes direct annual premiums of two million dollars or less, and

(3) Assumes no reinsurance in excess of five percent of direct premium written.

Acts 1995, No. 1203, §1, eff. June 29, 1995.

§869. Foreign insurers

A.(1) Any foreign insurer shall submit to the department upon written request, a risk-based capital report as of the end of the preceding calendar year but not later than the date a risk-based capital report would be required to be filed by a domestic insurer under this Part or fifteen days after the request is received by the foreign insurer.

(2) Any foreign insurer shall promptly submit to the department upon written request, a copy of any risk-based capital report that is filed with the insurance department of any other state.

B. In the event of a company-action level event, regulatory-action level event, or authorized-control level event of any foreign insurer as determined under the risk-based capital statute applicable in the state of domicile of the insurer or, if no risk-based capital statute is in force in that state, under the provisions of this Part, if the insurance department of the state of domicile of the foreign insurer fails to require the foreign insurer to file a risk-based capital plan in the manner specified under that state's risk-based capital statute or, if no risk-based capital statute is in force in that state, under R.S. 22:862 hereof, the department may require the foreign insurer to file a risk-based capital plan with the department. In such event, the failure of the foreign insurer to file a risk-based capital plan with the department shall be grounds to order the insurer to cease and desist from writing new insurance business in this state.

C. In the event of a mandatory-control level event with respect to any foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the department may make application to the Nineteenth Judicial District Court for and in the parish of East Baton Rouge in accordance with the Louisiana Insurance Code with respect to the liquidation of property of the foreign insurers located in the state. The occurrence of the mandatory-control level event shall be considered adequate grounds for the application to the court.

Acts 1995, No. 1203, §1, eff. June 29, 1995.

PART XIX. RESERVES FOR INSURANCE OTHER THAN LIFE

§891. Unearned premium reserve

A. With reference to insurance against loss or damage to property, except as provided in R.S. 22:892, and with reference to all general casualty insurance, health and accident insurance except as provided in RS. 22:893, and surety insurance, every insurer shall maintain an unearned premium reserve on all policies in force.

B.(1) The commissioner of insurance may require that such reserve shall be equal to the unearned portions of the gross premiums in force after deducting authorized reinsurance, as computed on each respective risk, from the policy's date of issue.

(2) If the commissioner of insurance does not so require, then the unearned portions of the gross premiums in force, less authorized reinsurance which shall be held as a premium reserve, shall be computed according to the following table.

Term for Which Policy Was Written	Reserve for Unearned Premium
One year, or less	1/2
Two years:	
First year	3/4
Second year	1/4
Three years:	
First year	5/6
Second year	1/2
Third year	1/6
Four years:	
First year	7/8
Second year	5/8
Third year	3/8
Fourth year	1/8
Five years:	
First year	9/10
Second year	7/10
Third year	1/2
Fourth year	3/10
Fifth year	1/10
Over five years	Pro rata

(3) In lieu of computation according to such table, all of such reserves may be computed, at the insurer's option, on a monthly pro rata basis.

(4) After adopting any one of the methods for computing such reserve, an insurer shall not change methods without the commissioner of insurance's approval.

Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996.

§891.1. Restrictions on maximum and annual premiums written

A. Whenever the commissioner has reason to believe that the financial condition of an insurer endangers the interests of its policyholders and the insurer's ratio of actual or projected annual net premiums to current surplus as to policyholders exceeds four to one, the commissioner may by order establish maximum net annual premiums to be written by the insurer consistent with maintaining the ratio specified herein. The order shall not exceed six months in duration.

B. Projected annual net premiums shall be based on the actual writings to date for the insurer's current calendar year or the insurer's writings for the previous calendar year, or both. The ratio shall be computed on an annualized basis.

C. This Section shall not apply to life or health insurers.

D. When computing the ratio of actual or projected annual net premiums to current surplus as to policyholders, as provided by Subsection A herein, policy fees shall not be included in the compilation of actual or projected annual net premiums.

Acts 1990, No. 881, §1, eff. Jan. 1, 1991; Acts 1991, No. 207, §1, eff. July 2, 1991.

§892. Reserve for marine and transportation (inland marine) insurance

In the case of policies of marine or inland navigation or transportation insurance the unearned premium reserve, to be charged as a liability shall be fifty per cent of the amount of the premiums upon risks covering not more than one passage not terminated and shall be upon a pro rata basis for all other policies.

Acts 1958, No. 125.

§893. Reserves--noncancellable health and accident insurance

A. The legal minimum standard for computing the active life reserve, including the unearned premium reserve, of noncancellable health and accident policies shall be based on Conference Modification of Class III Disability Experience with interest at not to exceed three and one-half percent per annum on the full preliminary term basis.

B. For policies with a waiting period of less than three months or providing benefits at ages beyond the limits of Conference Modification of Class III Disability Experience, the tables shall be extended to cover the provisions of such policies on such basis as the commissioner of insurance may approve.

C. The reserve for losses under noncancellable disability policies shall be based on Conference Modification of Class III Disability Experience, except that for claims of less than twenty-seven months' duration the reserve may be taken as equivalent to the prospective claim payments for three and one-half times the elapsed period of disability; but in no case shall the reserve be less than the equivalent of seven weeks' claim payments.

D. For a point of service policy, reserves shall be required for the indemnity exposure only and may be based on an insurer's actual experience or, in the case of an insurer in business for less than five years, may be based on industry standards.

E. The commissioner of insurance shall modify the application of the tables and requirements prescribed in this Section to policies or to claims arising under policies in accordance with the waiting period contained in such policies and in accordance with any limitation as to the time for which indemnity is payable.

Acts 1958, No. 125; Acts 1999, No. 878, §1, eff. July 2, 1999.

§894. Loss records

Every insurer shall maintain a complete and itemized record showing all losses and claims as to which it has received notice, and all notices received of the occurrence of any event which may result in a loss.

Acts 1958, No. 125.

§895. Loss reserves

The loss reserves of every insurer shall be at least equal to the aggregate estimated amounts due or to become due on account of all losses or claims of which the insurer has received notice, including the estimated liability arising out of the occurrence of any event which may result in a loss and of which the insurer has received notice, and the estimated liability for all losses which have occurred but of which no notice has been received.

Acts 1958, No. 125. Acts 1983, 1st Ex.Sess., No. 1, §6; Acts 1997, No. 549, §1.

§896. REPEALED BY ACTS 1997, No. 549, §2.
§897. REPEALED BY ACTS 1997, No. 549, §2.
§898. REPEALED BY ACTS 1997, No. 549, §2.
§899. REPEALED BY ACTS 1997, No. 549, §2.
§900. Schedule of experience

Any insurer transacting any liability or worker's compensation insurances shall include in its annual statement filed with the commissioner of insurance, a schedule of its experience thereunder in such form as the commissioner of insurance may prescribe.

Acts 1958, No. 125. Acts 1983, 1st Ex.Sess., No. 1, §6.

§901. Special reserve fund; title insurance

Each title insurer shall annually apportion to a special reserve fund an amount determined by applying the rate of twenty-five cents for each one thousand dollars of net increase of insurance it has in force as at the end of such year. Such apportionment shall be continued or resumed as needed to maintain the special reserve fund at an amount equal to not less than the guaranty fund deposit required of the insurer.

The special reserve fund shall be held by the insurer as additional guaranty fund, and shall be used only for the payment of losses after the insurer's liquid resources available for the payment of losses, other than such special reserve fund or the guaranty fund deposit, have been exhausted.

For the purposes of computing the special reserve fund as provided in paragraph one of this Section, net increases of insurance in force resulting from reinsurance of the risks of another title insurer shall not be included to the extent that a like special reserve fund on such insurance is maintained by the ceding insurer.

Acts 1958, No. 125.

§902. Increased reserves

If the commissioner of insurance determines that an insurer's unearned premium reserves, however computed, are inadequate, he may require the insurer to compute such reserves or any part thereof according to such other method or methods as are prescribed in this Part.

If the loss experience of an insurer shows that its loss reserves however estimated, are inadequate, the commissioner of insurance shall require the insurer to maintain loss reserves in such increased amount as is needed to make them adequate.

Acts 1958, No. 125.

§903. "Loss payments"; "loss expense" defined

"Loss payments" and "loss expense payments" as used with reference to liability and worker's compensation insurances shall include all payments to claimants, payments for medical and surgical attendance, legal expenses, salaries and expenses of investigators, adjusters and claims fieldmen, rents, stationery, telegraph and telephone charges, postage, salaries and expenses of office employees, home office expenses and all other payments made on account of claims, whether such payments are allocated to specific claims or are unallocated.

Acts 1958, No. 125. Acts 1983, 1st Ex.Sess., No. 1, §6.

§904. Actuarial certification of loss reserve

A. Beginning January 1, 1997, the loss reserves shall be accompanied by a statement of the opinion of an associate or fellow of the Casualty Actuarial Society or other qualified loss reserve specialist, setting forth his opinion relative to the reasonableness and sufficiency of loss and loss adjustment expense reserves.

B. The commissioner of insurance shall adopt reasonable rules and regulations for the implementation and administration of the provisions of this requirement, with due consideration of the establishment of a proper phase-in, thresholds for certification requirements based on premium volume or product lines or both, insurance solvency standards tests as performed by the National Association of Insurance Commissioners, and the financial condition of each insurer to which these requirements apply. The rules and regulations shall be promulgated by the commissioner no later than November 1, 1996.

Acts 1996, 1st Ex. Sess. , No. 71, §1, eff. May 10, 1996; Acts 1997, No. 549, §1.

PART XX. REINSURANCE

§941. Reinsurance credits

A. Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or deduction from liability when the assuming insurer satisfies the requirements of Subsection B, C, D, or E of this Section. If the requirements of Subsection D are satisfied, the requirements of Subsection F of this Section shall also be satisfied.

B. Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is authorized in this state. An authorized insurer is one which holds a certificate of authority to transact insurance or reinsurance.

C. Credit shall also be allowed when the reinsurance is ceded to an assuming insurer which is accredited as a reinsurer in this state. An accredited reinsurer shall be approved by the Department of Insurance after filing an application for accreditation, and:

(1) Filing with the Department of Insurance evidence of its submission to the jurisdiction of this state, and as may be set forth by the department in regulations.

(2) Submission of the reinsurer to the authority of the Department of Insurance to examine books and records of the reinsurer.

(3) Demonstration by the reinsurer that the reinsurer is licensed or authorized to transact insurance or reinsurance in, or in the case of a United States branch of an alien assuming insurer, is entered through, at least one state which employs standards regarding credit for reinsurance equal to or exceeding those applicable under this Part.

(4) Annual filing with the Department of Insurance a true copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement.

D.(1)(a) Credit shall also be allowed under Subparagraph (2) when the reinsurance is ceded to an assuming insurer which maintains a trust fund in a qualified United States financial institution, as defined in R.S. 22:941.2(B), for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns, and successors in interest. The assuming insurer shall report and submit annually to the commissioner information substantially the same as that required to be reported on the National Association of Insurance Commissioners (NAIC) annual statement form by authorized insurers to enable the commissioner to determine the sufficiency of the trust fund.

(b) Any credit for reinsurance shall not be granted under Subparagraph (2) unless the form of the trust and amendments to the trust have been approved by the Department of Insurance. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in the trustees of the trust for its United States ceding insurers, their assigns, and successors in interest. The trust shall be subject to examination as determined by the department. The trust described herein shall remain in existence for as long as the assuming insurer shall have obligations due under the reinsurance agreements subject to the trust.

(c) Not later than the twenty-eighth day of each February, the trustees of the trust established under Subparagraph (2) shall provide a written report to the department setting forth the balance of the trust and listing the investments of the trust of the preceding calendar year, and shall certify the date of termination of the trust, if so planned, or shall certify that the trust shall not expire prior to the succeeding December thirty-first.

(2)(a) In the case of a single assuming insurer, the trust shall consist of a trusteed account in an amount not less than the assuming insurer's liabilities attributable to business written in the United States and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than twenty million dollars.

(b) In the case of a group of insurers that include individual unincorporated underwriters, the trust shall consist of a trusteed account representing the group's liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of which one hundred million dollars shall be held jointly for the benefit of United States ceding insurers of any member of the group. The group shall make available to the commissioner an annual certification of the solvency of each underwriter by its domiciliary regulator and its independent public accountants.

(c) In the case of a group of incorporated insurers under common administration, the group shall:

(i) Submit to this state's authority to examine its books and records and bear the expense of the examination.

(ii) Maintain aggregate policyholders' surplus of ten billion dollars.

(iii) Maintain a trust consisting of a trusteed account in an amount not less than the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group.

(iv) In addition, maintain a joint trusteed surplus of which one hundred million dollars shall be held jointly for the benefit of the United States ceding insurers of any member of the group as additional security for these liabilities.

(v) Within ninety days after its financial statements are due to be filed with the group's domiciliary regulator make available to the commissioner an annual certification of the member's solvency by the member's domiciliary regulator and financial statements of each underwriter member of the group audited by independent public accountants.

E. Any credit for reinsurance shall also be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of Subsection B, C, or D of this Section, only as to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law of that jurisdiction.

F. If the assuming insurer is not authorized or accredited to transact insurance or reinsurance in this state, credit permitted by Subsection D shall not be allowed unless:

(1) The assuming insurer provides the following in all reinsurance agreements:

(a) That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, comply with all requirements necessary to give such court jurisdiction, and abide by the final decision of the district court or appellate court.

(b) To designate the commissioner as its true and lawful attorney, who may be served any lawful service of process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer.

(c) The provisions of Subparagraphs (a) and (b) of this Paragraph shall not be construed to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if such an obligation is created in the reinsurance agreement.

(2) The assuming insurer files with the department a list identifying its officers and directors, or similar principals, along with biographical information for each and provides an annual update of this information.

(3) The assuming insurer agrees to allow the department to examine its books and records and to waive any protection it has under any secrecy laws of its domiciliary jurisdiction of the reinsurer, except that any examination shall only take place upon showing of good cause by the department for concern about the financial soundness or solvency of the subject entity.

G. The ceding insurer may take credit for the reserves on such ceded risks to the extent reinsured, except that:

(1) No credit shall be taken for such reserves unless the insurer accepting the reinsurance meets the requirements set forth in this Section as valid assuming insurers.

(2) No credit shall be allowed to any ceding insurer for reinsurance, as an admitted asset or as a deduction from liability, unless the reinsurance shall be payable, in the event of insolvency of the ceding insurer, to its liquidator or receiver on the basis of the claim or claims allowed against the insolvent ceding insurer by any court of competent jurisdiction or any justice or judge thereof, or by any receiver or liquidator having authority to determine and allow such claims, except either where the reinsurance contract with the consent of the direct insured or insureds specifically provides another payee of such reinsurance in the event of the insolvency of the ceding insurer, or when the assuming insurer with the consent of the direct insured or insureds has assumed such policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under such policies and in substitution for the obligations of the ceding insurer to such payees.

(3) No credit for reinsurance shall be permitted unless the assuming insurer has been doing business in its country of domicile for at least three years, or is an affiliate of an insurer or reinsurer which has been doing business in its country of domicile for at least three years, unless the department, for good cause shown, waives this three-year operating requirement by rule or regulation.

Acts 1958, No. 125; Acts 1985, No. 510, §1; Acts 1988, No. 168, §1, eff. Sept. 1, 1988; Acts 1989, No. 560, §1, eff. Sept. 1, 1989; Acts 1990, No. 673, §1; Acts 1991, No. 996, §1, eff. Jan. 1, 1992; Acts 1993, No. 788, §1; Acts 1993, No. 902, §1; Acts 1995, No. 1182, §1.

§941.1. Reduction from liability for ceded reinsurance

A reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer that fails to satisfy the requirements of R.S. 22:941 shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer, and such a reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust in this state for the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder, if such security is held in this state subject to withdrawal solely by, and under the exclusive control of, the ceding insurer, or, in the case of a trust, held in a qualified United States financial institution, as defined in R.S. 22:941.2(B). The security may be in the form of:

(1) Cash.

(2) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners (NAIC) and qualifying as admitted assets.

(3)(a) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States institution, as defined in R.S. 22:941.2(A), effective no later than December thirty-first in respect of the year for which filing is being made, and in possession of or in trust for the ceding company on or before the filing date of its annual statement.

(b) Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever occurs first.

(4) Any other form of security acceptable to the commissioner.

Acts 1991, No. 996, §1, eff. Jan. 1, 1992; Acts 1995, No. 1182, §1.

§941.2. Qualified United States financial institutions

A. Only for purposes of R.S. 22:941.1(3), a "qualified United States financial institution" means an institution which:

(1) Is organized, or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state thereof.

(2) Is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies.

(3) Has been determined by either the commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners (NAIC) to satisfy the standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit may be acceptable to the commissioner.

B. For other provisions of this Part specifying those institutions that are eligible to act as a fiduciary of a trust, a "qualified United States financial institution" means an institution that:

(1) Is organized, or in the case of a United States branch or agency office of a foreign banking organization, licensed under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers.

(2) Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

Acts 1991, No. 996, §1, eff. Jan. 1, 1992.

§941.3. Calculation of reinsurance credits

A. For the purpose of determining the financial condition of a ceding insurer, only if such reinsurance is effected by the ceding insurer in any assuming insurer authorized to do such business in this state, the ceding insurer shall, in addition to any credit allowed against its loss reserves, receive credit for such reinsurance calculated in the following manner:

(1) In the case of reinsurance of the whole or any part of any risk other than as specified in Paragraph (2) following, the ceding insurer shall receive credit for such reinsurance by way of deduction from its unearned premium liability calculated in accordance with the provisions of Part XIX.

(2) In the case of reinsurance of the whole or any part of any life insurance or annuity or noncancellable disability risk, the ceding insurer shall receive credit, by way of deduction from its reserve liability, in an amount not exceeding the amount of the reserve on the reinsured portion of such risk which the ceding insurer would have maintained if such portion had not been reinsured.

B. For the purpose of determining the financial condition of any assuming insurer, the assuming insurer shall be charged with an amount in its unearned premium liability equal to the amount of the deduction specified in Paragraph (1) of Subsection A of this Section and in its valuation reserve liability with an amount at least equal to the amount which it would be required to maintain in accordance with the provisions of this Part if it were the direct insurer of such assumed risks on the basis specified in the reinsurance agreement.

Acts 1991, No. 996, §1, eff. Jan. 1, 1992; Acts 1995, No. 1182, §2.

§941.4. Unearned premium reserve; reduction below required amount prohibited

Nothing contained in R.S. 22:941 through 941.4 shall be deemed to permit the ceding insurer to receive through the cession of the whole or any part of any risk or risks any advantage whereby its unearned premium reserve, or the net amount of its valuation reserves, as the case may be, is reduced below the required amount thereof by the provisions of this Part.

Acts 1991, No. 996, §1, eff. Jan. 1, 1992; Acts 1995, No. 1182, §2.

§942. Agreements requiring approval

A. The following kinds of reinsurance agreements shall not be entered into by any domestic insurer unless they are first submitted to the commissioner of insurance for his written approval, who shall approve the same if the terms thereof do not injuriously affect the rights of policyholders of any of the insurers parties thereto:

(1) Agreements of reinsurance of any life insurer other than agreements made in the ordinary course of business covering reinsurance of individual lives or joint lives under reinsurance agreements relating to current business; or

(2) Agreements whereby any insurer, other than a life insurer, cedes any existing outstanding reserves to an insurer not authorized to transact business in this state, or cedes to any insurer, or insurers, at one time or during a period of six consecutive months, more than twenty percent of the total amount of its outstanding reserves, not including premiums ceded by agreements made in the ordinary course of business covering the reinsurance of individual risks under reinsurance relating to current business.

B. If the commissioner of insurance refuses to approve any such agreement submitted for his approval, he shall grant the insurer a hearing upon request.

C. In addition to the requirements of Subsection A of this Section, the commissioner may require that any reinsurance agreement must be approved in writing by the commissioner when the agreement is between a Louisiana domestic insurer and a nonadmitted or unauthorized assuming insurer.

Acts 1958, No. 125; Acts 1993, No. 788, §1; Acts 1995, No. 1182, §1.

§943. Pending actions

A. Whenever an insurer agrees to assume and carry out directly with the policyholder any of the policy obligations of the ceding insurer under a reinsurance agreement, any claim existing or action or proceeding pending arising out of such policy by or against the ceding insurer with respect to such obligations may be prosecuted to judgment as if such reinsurance agreement had not been made, or the assuming insurer may be substituted in place of the ceding insurer.

B. Where two or more assuming insurers are involved in the same claim and a majority in interest elect to interpose defense to such claim, the expense shall be apportioned in accordance with the terms of the reinsurance agreement as though such expense had been incurred by the ceding insurer.

Acts 1958, No. 125; Acts 1991, No. 996, §1, eff. Jan. 1, 1992.

§944. Certificate of fees and commissions paid

Whenever a reinsurance agreement is submitted to the commissioner of insurance for his approval, there shall be filed with him a certificate with regard to fees, commissions and other compensations or valuable considerations paid or to be paid to any person directly or indirectly in connection with the agreement.

Acts 1958, No. 125.

§945. Pecuniary interest of directors and officers

No director or officer of any insurer, party to a reinsurance agreement, except as fully expressed in the reinsurance agreement, shall receive any fee, commission, other compensation or valuable consideration whatever, directly or indirectly, for in any manner aiding, promoting or assisting in the negotiation of such reinsurance agreement.

Acts 1958, No. 125; Acts 1995, No. 1182, §2.

§946. Unauthorized insurers

It shall be unlawful for a domestic insurer to assume reinsurance from another insurer on lines of insurance such domestic insurer is not authorized to write in the state of Louisiana.

Added by Acts 1979, No. 316, §1; Acts 1995, No. 1182, §2.

§947. Authorization; hearings on violations

A. The commissioner may adopt, pursuant to the provisions of the Administrative Procedure Act, rules and regulations to implement any provision of this Part.

B. The commissioner may conduct hearings in accordance with Part XXIX of this Title on any matters arising out of the application or violation of the provisions of this Part or any rules and regulations promulgated pursuant thereto.

Acts 1991, No. 996, §1, eff. Jan. 1, 1992; Acts 1995, No. 1182, §2.

§948. REPEALED BY ACTS 1995, No. 1124, §2.

PART XXI. FOREIGN OR ALIEN INSURERS

§981. Foreign or alien insurers may be admitted

Any foreign or alien insurer, including reciprocals, Lloyds and fraternals, may be admitted to transact business in this state, upon complying with the provisions of this Part, and all other applicable provisions of this Code, to transact the kind or kinds of business which a similar domestic insurer may legally transact under this Code, except non-profit funeral insurance, and life, health and accident insurers on the co-operative or assessment plan, provided insurers admitted to transact the kinds of business provided in Parts VII[1] and VIII[2] shall meet the requirements for life insurers under Parts III[3] and IV.[4]

Any foreign insurance company which has been licensed to do the business of life insurance in this state continuously during a period of ten years next preceding October 1, 1948, may continue to be licensed to do the kind or kinds of insurance business which it was authorized to do immediately prior to October 1, 1948.

Acts 1958, No. 125.

[1]R.S. 22:251 to 22:260.

[2]R.S. 22:291 to 22:294.

[3]R.S. 22:71 to 22:84.

[4]R.S. 22:121 to 22:132.

§982. Application for certificate of authority

A. A foreign or alien insurer in order to procure a certificate of authority to transact business in this state shall prepare and deliver to the commissioner of insurance:

(1) Two copies of its charter or articles of incorporation, certified by the proper official of its domiciliary state or country, or if a reciprocal or Lloyds the power of attorney of the attorney-in-fact; and if an alien insurer two copies of the appointment and authority of its United States manager.

(2) An instrument authorizing service of process on the secretary of state, as required by R.S. 22:985.

(3) An application setting forth its name, location of home office, type of insurer, organization date, kinds of insurance it proposes to transact in this state, except for reinsurers licensed or accredited by the state, the location and telephone number of the applicant's supervisory claims office responsible for Louisiana claims, the name of a qualified appointed actuary who will provide actuarial opinions when required by the state of Louisiana, and such additional information, including biographical information, as the commissioner of insurance may reasonably require to determine if the applicant is entitled to a certificate.

(4) A copy of its by-laws, and if a fraternal society, a copy of its constitution, certified by its proper officers.

(5) A copy of the applications and insurance contracts it proposes to use in this state.

(6) A copy of its last annual statement and a financial statement as of such later date as the commissioner of insurance may require.

(7) A copy of the last report of examination certified by a proper supervisory official.

(8) A certificate from the proper official of its domiciliary state or country that it is duly incorporated or organized and is presently authorized to write the kind or kinds of insurance which it proposes to write in this state.

(9) Such other documents or stipulations as the commissioner of insurance may reasonably require to evidence compliance with the provisions of this Code.

(10) A certificate of valuation of reserves by the domiciliary state which meets the minimum standards of valuation for the state of Louisiana.

(11) REPEALED BY ACTS 2001, No. 276, §2.

(12) REPEALED BY ACTS 2001, No. 276, §2.

(13) A certificate from the proper official of the domiciliary state of the company applying for admission to the state of Louisiana showing that a deposit has been made in the domiciliary state of the foreign insurer in an amount of not less than one hundred thousand dollars, as evidenced by a safekeeping or trust receipt, for the benefit and protection of and as security for all policyholders and creditors of the insurer making such deposit.

B. Upon approval by the commissioner of insurance, a certified copy of the instrument authorizing service of process on the secretary of state, as required by R.S. 22:985 shall be recorded with the secretary of state by the said commissioner.

C. The secretary of state is authorized and directed to transfer to the commissioner of insurance those documents now on record in the office of the secretary of state and described in Paragraph A(1) pertaining to foreign or alien insurers now or hereafter authorized to transact the business of insurance in this state, after having first reproduced said documents for preservation in the records of the secretary of state.

Acts 1958, No. 125. Amended by Acts 1960, No. 391, §1; Acts 1992, No. 704, §1; Acts 1993, No. 59, §1; Acts 1993, No. 811, §1; Acts 1993, No. 951, §1; Acts 1995, No. 1229, §1; Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996; Acts 1999, No. 342, §6; Acts 2001, No. 276, §§1 & 2; Acts 2003, No. 130, §1; Acts 2004, No. 377, §1.

§983. Conditions of issuance of certificate of authority

A. After the requirements of R.S. 22:982 have been completed and before a certificate of authority is issued by the commissioner of insurance, a foreign or alien insurer shall satisfy the commissioner of insurance that:

(1) Its name is not the same as, or deceptively similar to the name of any other insurer already authorized to transact business in this state;

(2) It is possessed of at least the minimum capital and surplus requirements for similar domestic insurers authorized to transact like kinds of insurance which it is authorized to transact in the state of its domicile or entry, including:

(a) If a stock insurer, at least the minimum paid-in capital, and total capital and surplus equal to or greater than the sum of the minimum paid-in capital, minimum surplus, and the operating surplus.

(b) If a mutual insurer, total surplus equal to or greater than the sum of the initial minimum surplus and the operating surplus.

(c) If a mutual or reciprocal insurer, writing non-assessable policies, the surplus requirement for a similar domestic mutual insurer to issue non-assessable policies.

(3) Its funds are invested in accordance with the laws of its domicile.

B. Before issuance of the certificate of authority to a foreign or alien insurer, such insurer shall make a deposit as required by Part XXII.

C. Before issuance of the certificate of authority to an alien insurer, such insurer shall make a deposit as required by Part XXII and must maintain within the United States assets in amount not less than its outstanding liabilities arising out of its insurance transactions in the United States, and which assets shall be in addition to the larger of the following sums:

(1) The largest amount of deposit required by this Code to be made in this state by any type of domestic insurer transacting like kinds of insurance; or

(2) Two hundred thousand dollars. The trust deposit shall be for the security of all policyholders or policyholders and obligees of the insurer in the United States. It shall not be subject to diminution below the amount currently determined in accordance with this Subsection so long as the insurer has outstanding any liabilities arising out of its business transacted in the United States.

The trust deposit shall be maintained with public depositories or trust institutions within the United States approved by the commissioner of insurance.

D. Before issuing a certificate of authority to a foreign or alien insurer, the commissioner of insurance may cause an examination to be made of its condition and affairs.

E. The transacting of business in this state by a foreign or alien insurer pursuant to a certificate of authority issued under this Part shall constitute a consent to being sued by the injured person or his or her heirs in a direct action as provided in R.S. 22:655, whether the policy of insurance sued upon was written or delivered in the state of Louisiana or not, and whether or not such policy contains a provision forbidding such direct action, provided that the accident or injury occurred within the state of Louisiana.

Acts 1958, No. 125. Amended by Acts 1969, No. 74, §1; Acts 1999, No. 507, §1; Acts 2003, No. 130, §1; Acts 2004, No. 377, §1.

§984. Trust deposit resolution

An alien insurer shall file with the commissioner of insurance a certified copy of the resolution of its governing board by which the trust deposit was established, together with a certified copy of any trust agreement under which the deposit is held.

Acts 1958, No. 125.

§985. Service of process; secretary of state as attorney

Every foreign or alien insurer shall appoint the secretary of state to be its true and lawful attorney in this state upon whom, or some other person in his office during his absence he may designate, all lawful process in any action or proceeding against such insurer may be served, which shall constitute service on such insurer. Such appointment shall continue in force so long as any contract or other liability of such insurer in this state shall remain outstanding. Whenever such process shall be served upon the secretary of state, he shall forthwith forward a copy of the process by prepaid registered mail or by commercial courier as defined in R.S. 13:3204(D), when the person to be served is located outside of this state to the person designated for the purpose by the insurer.

Acts 1958, No. 125; Acts 1999, No. 395, §4.

§986. Issuance of certificate of authority

When a foreign or alien insurer has complied with all of the requirements imposed upon it by this Code, the commissioner of insurance shall issue such insurer a certificate of authority to transact in this state the kind or kinds of business specified therein. Such certificate shall expire on the thirty-first day of March next succeeding its issue, and shall be renewable annually thereafter if such insurer continues to meet all of the requirements imposed upon it by this Code or any amendments thereto.

Acts 1958, No. 125.

§987. Refusal, suspension, and revocation of certificate of authority

A. The commissioner of insurance may refuse, suspend, or revoke the certificate of authority of a foreign or alien insurer whenever he shall find that such insurer:

(1) Is insolvent;

(2) Fails to comply with the requirements for admission in respect to capital, contingent liability, the investment of its assets or the maintenance of deposits in this or another state or fails to maintain the surplus which similar domestic insurers transacting the same kind or kinds of business are required to maintain;

(3) Is in such a condition that its further transaction of business in this state would be hazardous to policyholders and creditors in this state and to the public;

(4) Has refused or neglected to pay a valid final judgment against such insurer within sixty days after the rendition of such judgment;

(5) Has violated any law of this state or has in this state violated its charter or exceeded its corporate powers;

(6) Has refused to submit its books, papers, accounts, records, or affairs to the reasonable inspection or examination of the commissioner of insurance, his actuaries, supervisors, deputies or examiners;

(7) Has an officer who has refused upon reasonable demand to be examined under oath touching its affairs;

(8) Fails to file its annual statement within sixty days after the date when it is required by law to file such statement;

(9) Fails to file a copy of an amendment to its charter or articles of incorporation within sixty days after the effective date of such amendment, in accordance with the provisions of this Part;

(10) Fails to file copies of the agreement and certificate of merger and the financial statements of the merged insurers, if required, within sixty days after the effective date of the merger, as provided in this Part;

(11) Fails to pay any fees, taxes or charges prescribed by this Code within sixty days after they are due and payable; provided, however, that in case of objection or legal contest the insurer shall not be required to pay the tax until sixty days after final disposition of the objection or legal contest;

(12) Fails to file any report or reports for the purpose of enabling the commissioner of insurance to compute the taxes to be paid by such insurer within sixty days after the date when it is required by law to file such report or reports;

(13) Has had its corporate existence dissolved or its certificate of authority revoked or suspended in the state in which it was organized or in any other state in which it is admitted;

(14) Has had all its risks reinsured in their entirety in another insurer;

(15) Refuses to remove or discharge a director or officer who has been convicted of any crime involving fraud, dishonesty, or like moral turpitude; or

(16) Is affiliated with and under the same general management, or interlocking directorate, or ownership as another insurer which transacts insurance in this state without having a certificate of authority therefor, except as is permitted by this Code.

(17) Fails to maintain a claims office for processing workers' compensation insurance claims in this state, as required by R.S. 23:1161.1, or to retain the services of Louisiana domiciled independent claims adjusters. This Paragraph shall not apply to reinsurers licensed or accredited to do business in the state.

(18) Fails to require its producers or agents to maintain licensure as producers or agents as provided by law or by regulation of the Department of Insurance.

(19) Fails to file required biographical information within sixty days of the appointment of officers and directors appointed after issuance of the certificate of authority.

B. Except for the grounds stated in Paragraphs 1, 11, 13 and 14 of Subsection A of this Section, the commissioner of insurance shall not revoke or suspend the certificate of authority of a foreign or alien insurer until he has given the insurer at least thirty days notice of the proposed revocation or suspension and of the grounds therefor and has afforded the insurer an opportunity for a hearing.

C. Upon such refusal, suspension or revocation, the commissioner of insurance shall likewise refuse, suspend or revoke the authority of the insurer's agents in this state and give notice thereof to such agents.

D. The commissioner of insurance shall not suspend an insurer's certificate of authority for a period in excess of one year, and he shall state in his order of suspension the period during which it shall be effective.

E. No insurer whose certificate of authority has been suspended, revoked, or refused shall subsequently be authorized unless the grounds for such suspension, revocation, or refusal no longer exist and the insurer is otherwise fully qualified.

Acts 1958, No. 125. Amended by Acts 1960, No. 152, §1; Acts 1990, No. 680, §1, eff. July 20, 1990; Acts 1993, No. 811, §1; Acts 1995, No. 1229, §1; Acts 2001, No. 276, §1; Acts 2003, No. 130, §1.

§988. Amendment to certificate of authority

A. In the event that a foreign or alien insurer authorized to transact business in this state changes its name or desires to transact in this state a kind or kinds of business other than those it is then authorized to transact, it shall file with the commissioner of insurance an application for an amended certificate of authority.

B. Such application shall comply as to form and manner of execution with the requirements of this Part for an original application and shall set forth the name of the insurer, the respects in which the insurer desires its certificate of authority amended, and such other information as is necessary or appropriate to enable the commissioner of insurance to determine whether such an amended certificate of authority should be issued.

C. The commissioner of insurance shall issue such amended certificate if he is satisfied that:

(1) The insurer might lawfully be authorized to transact the kind or kinds of business it desires to transact if application for such authority were made in an original application; and

(2) The conditions provided for in R.S. 22:983 are complied with.

Acts 1958, No. 125.

§989. Filing amendment to articles of incorporation

Whenever the articles of incorporation of a foreign or alien insurer authorized to transact business in this state shall be amended, such insurer shall, within thirty days after the effective date of such amendment, file with commissioner of insurance two certified copies thereof duly authenticated by the proper official of its domiciliary state or country. The filing of such copy shall not of itself enlarge the authority of the insurer in the transaction of business in this state, nor authorize such insurer to transact business in this state under any other name than the name set forth in its certificate of authority.

Acts 1958, No. 125. Amended by Acts 1960, No. 391, §1.

§990. Procedure following merger or consolidation

A. Whenever a foreign or alien insurer authorized to transact business in this state shall be the surviving insurer of a statutory merger permitted by the laws of the state or country under which it is organized, and such merger is not subject to the provisions of Part XVI,[1] it shall forthwith file with the commissioner of insurance:

(1) Two copies of the agreement and certificate of merger duly authenticated by the proper official of the state or country under the laws of which such statutory merger was effected, one of which copies shall be retained by the commissioner of insurance, and one of which certified copies shall be filed with the secretary of state by said commissioner.

(2) If any of the insurers party to such merger were not admitted to transact business in this state, a statement of the financial condition and business of each of such insurers, as of the end of the preceding calendar year complying as to form, content and verification with the requirements of this Code for annual statements, or a financial statement as of such later date as the commissioner of insurance may require.

B. It shall not be necessary for such surviving insurer to procure a new certificate of authority to transact business in this state nor an amended certificate unless the name of such insurer be changed thereby or unless the insurer desires to transact in this state a kind or kinds of business other than those which it is then authorized to transact.

C. Whenever a foreign or alien insurer authorized to transact business in this state shall be a party to a statutory merger and such insurer shall not be the surviving insurer, or if such foreign or alien insurer shall be a party to a consolidation, then the certificate of authority of such foreign or alien insurer shall terminate upon such merger or consolidation, and the surviving insurer, if not previously authorized to transact business in this state, or the new insurer, in the case of consolidation, shall be subject to the same requirements for admission to transact business in this state as any other foreign or alien insurer.

Acts 1958, No. 125. Amended by Acts 1960, No. 391, §1.

[1]R.S. 22:731 to 22:764.

§991. Withdrawal from state; deposit

A. Any foreign or alien insurer admitted to do business in this state may withdraw from this state by filing with the commissioner of insurance a statement of withdrawal, signed and verified by a president, vice-president or an executive officer corresponding thereto, or in the case of a reciprocal or Lloyds, by the attorney-in-fact, and setting forth:

(1) That the insurer surrenders its authority to transact business in this state and returns for cancellation its certificate of authority;

(2) Except in the case of a reciprocal or Lloyds, that the withdrawal of the insurer from this state has been duly authorized by the board of directors, trustees or other governing body of such insurer; and

(3) A post office address to which the secretary of state may mail a copy of any process against the withdrawing insurer that may be served upon him, which address the commissioner of insurance shall furnish to the secretary of state;

(4) That the insurer agrees to settle claims arising from business in this state without prejudice because of such withdrawal.

B. Upon the filing of such statement together with its certificate of authority with the commissioner of insurance and payment of any taxes or charges that may be due, the commissioner of insurance shall cancel the certificate of authority and return the cancelled certificate to the insurer. The authority of the insurer to transact business in this state shall thereupon cease.

C. When a foreign or alien insurer has withdrawn from this state, or has had its certificate of authority to transact business in this state revoked, and such insurer desires to withdraw any deposit made in this state pursuant to this Code, the commissioner of insurance shall upon the application of the insurer and at its expense, give notice of such intention to the insurance commissioner or other proper supervisory official of each state or country in which the insurer is authorized to transact business, and shall publish notice of such intention in a newspaper of general circulation in this state once a week for four consecutive weeks. After such notice and publication the commissioner of insurance shall authorize the state treasurer to deliver to such insurer or its assigns the securities so deposited when he is satisfied upon examination and investigation made by him, or under his authority, and upon the oaths of the president and secretary or other chief officers of the insurer that all debts and liabilities of every kind due and to become due which the deposit was made to secure have been paid or otherwise extinguished.

Acts 1958, No. 125.

§992. REPEALED BY ACTS 1995, No. 1229, §2.

PART XXI-A. INSURANCE HOLDING COMPANY SYSTEM REGULATORY LAW

§1001. Title

This Part shall be known and may be cited as the "Insurance Holding Company System Regulatory Law".

Acts 1991, No. 794, §1.

§1002. Definitions

As used in this Part, the following terms shall have the respective meanings hereinafter set forth, unless the context shall otherwise require:

(1) "Affiliate" means a person who directly, or indirectly through one or more intermediaries, controls, or is controlled by or is under common control with, the person specified.

(2) "Commissioner" shall mean the commissioner of insurance, or his deputy, or the Department of Insurance, as appropriate.

(3) "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by R.S. 22:1005(K) that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(4) "Debt obligation" shall mean an obligation to repay a certain sum of money pursuant to specific conditions.

(5) "Insurance holding company system" consists of two or more affiliated persons, one or more of which is an insurer.

(6) "Insurer" shall have the same meaning as set forth in R.S. 22:5(2), except that it shall not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(7) "Person" means an individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing acting in concert, but shall not include any joint venture partnership exclusively engaged in owning, managing, leasing, or developing real or tangible personal property.

(8) "Securityholder" means one who owns any security of such person, including common stock, preferred stock, debt obligations, and any other security convertible into or evidencing the right to acquire any of the foregoing.

(9) "Subsidiary" means an affiliate controlled by such person directly or indirectly through one or more intermediaries.

(10) "Voting security" means any security convertible into or evidencing a right to acquire a voting security.

Acts 1991, No. 794, §1; Acts 1992, No. 811, §1.

§1003. Subsidiaries of insurers

A. Authorization. Any domestic insurer, as defined in R.S. 22:5(3), either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries. Such subsidiaries may conduct any kind of business or businesses, and their authority to do so will not be limited by reason of the fact that they are subsidiaries of a domestic insurer.

B. Additional investment authority. In addition to investments in common stock, preferred stock, debt obligations, and securities permitted under all other Sections of this Code, a domestic insurer may also:

(1) Invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts which do not exceed, for such additional investments, the lesser of either ten percent of such insurer's assets or fifty percent of such insurer's surplus as regards policyholders, provided that after such investments, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries shall be excluded, and there shall be included:

(a) Total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of such subsidiary whether or not represented by the purchase of capital stock or issuance of other securities, and

(b) All amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities and all contributions to the capital or surplus, of a subsidiary subsequent to its acquisition or formation.

(2) Invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer, provided that each subsidiary agrees to limit its investments in any asset so that such investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in Subsection B(1) of this Section or any other limitations set forth in this Code applicable to the insurer. For the purpose of this Section, "the total investment of the insurer" shall include:

(a) Any direct investment by the insurer in an asset, and

(b) The insurer's proportionate share of any investment in an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the ownership of such subsidiary.

(3) With the approval of the commissioner, invest any greater amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries, provided that after such investment the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

C. Exemption from investment restrictions. Investments in common stock, preferred stock, debt obligations, or other securities of subsidiaries made pursuant to Subsection B of this Section shall not be subject to any of the otherwise applicable restrictions or prohibitions contained in this Code applicable to such investments of insurers.

D. Qualification of investment; when determined. Whether any investment pursuant to Subsection B of this Section meets the applicable requirements thereof is to be determined before such investment is made, by calculating the applicable investment limitations as though the investment had already been made, taking into account the then outstanding principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested, not including dividends.

E. Cessation of control. If an insurer ceases to control a subsidiary, it shall dispose of any investment therein made pursuant to this Section within three years from the time of the cessation of control or within such further time as the commissioner may prescribe, unless, at any time after such investment shall have been made, such investment shall have met the requirements for investment under any other Section of this Code, and the insurer has notified the commissioner thereof.

Acts 1991, No. 794, §1.

§1004. Acquisition of control of or merger with domestic insurer

A. Filing requirements. No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities or, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would, directly or indirectly (or by conversion or by exercise of any right to acquire) be in control of such insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time any such offer, request, or invitation is made or any such agreement is entered into, or prior to the acquisition of such securities if no offer or agreement is involved, such person has filed with the commissioner and has sent to such insurer, a statement containing the information required by this Section, and such offer, request, invitation, agreement, or acquisition has been approved by the commissioner in the manner hereinafter prescribed.

(1) For the purposes of this Section a "domestic insurer" shall include any person controlling a domestic insurer unless such person as determined by the commissioner is either directly or through its affiliates primarily engaged in business other than the business of insurance.

(2) For purposes of this Section, "person" shall not include any securities broker holding, in the usual and customary brokers function, less than twenty percent of the voting securities of an insurance company or of any person which controls an insurance company.

B. Content of statement. The statement to be filed with the commissioner hereunder shall be made under oath or affirmation and shall contain the following information:

(1) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in Subsection A of this Section is to be effected, hereinafter called "acquiring party":

(a) If such person is an individual, his principal occupation and all offices and positions held during the past five years, and any conviction, of crimes other than minor traffic violations during the past ten years.

(b) If such person is not an individual, a report of the nature of its business operations during the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence; an informative description of the business intended to be done by such person and such person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of such person, or who perform or will perform functions appropriate to such positions. Such list shall include for each such individual the information required by Subparagraph (1)(a) of this Subsection.

(2) The source, nature, and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction wherein funds were or are to be obtained for any such purpose, including any pledge of the insurer's stock, or the stock of any of its subsidiaries or controlling affiliates, and the identity of persons furnishing such consideration, provided, however, that where a source of such consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential, if the person filing such statement so requests.

(3) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five fiscal years of each such acquiring party, or for such lesser period as such acquiring party and any predecessors thereof shall have been required by law to have such audited financial information, and similar unaudited information as of a date not earlier than ninety days prior to the filing of the statement.

(4) Any plans or proposals which each acquiring party may have to liquidate such insurer, to sell its assets, or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management.

(5) The number of shares of any security referred to in Subsection A of this Section which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement, or acquisition referred to in Subsection A of this Section, and a statement as to the method by which the fairness of the proposal was arrived at.

(6) The amount of each class of any security referred to in Subsection A of this Section which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party.

(7) A full description of any contracts, arrangements, or understandings with respect to any security referred to in Subsection A of this Section in which any acquiring party is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements, or understandings have been entered into.

(8) A description of the purchase of any security referred to in Subsection A of this Section during the twelve calendar months preceding the filing of the statement, by any acquiring party, including the dates of purchase, names of the purchasers, and consideration paid or agreed to be paid therefor.

(9) A description of any recommendations to purchase any security referred to in Subsection A of this Section made during the twelve calendar months preceding the filing of the statement, by any acquiring party, or by anyone based upon interviews or at the suggestion of such acquiring party.

(10) Copies of all tender offers for requests, or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in Subsection A of this Section, and, if distributed, of additional soliciting material relating thereto.

(11) The term of any agreement, contract, or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in Subsection A of this Section for tender, and the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard thereto.

(12) Such additional information as the commissioner may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

(13) If the person required to file the statement referred to in Subsection A of this Section is a partnership, limited partnership, syndicate, or other group, the commissioner may require that the information called for by Paragraphs (1) through (12) of this Subsection shall be given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group, and each person who controls such partner or member. If any such partner, member, or person is a corporation, or the person required to file the statement referred to in Subsection A is a corporation, the commissioner may require that the information called for by Paragraphs (1) through (12) of this Subsection shall be given with respect to such corporation, each officer, and director of such corporation, and each person who is directly or indirectly the beneficial owner of more than ten percent of the outstanding voting securities of such corporation.

(14) If any material changes occur in the facts set forth in the statement filed with the commissioner and sent to such insurer pursuant to this Section, an amendment setting forth such change, together with copies of all documents and other material relevant to such change, shall be filed with the commissioner and sent to such insurer within two business days after the person learns of such change.

C. Alternative filing materials. If any offer, request, invitation, agreement, or acquisition referred to in Subsection A of this Section is proposed to be made by means of a registration statement under the Securities Act of 1933 or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in Subsection A of this Section may utilize such documents in furnishing the information called for by that statement.

D. Approval by commissioner; hearings.

(1) The commissioner shall approve any merger or other acquisition of control referred to in Subsection A of this Section unless, after a public hearing held pursuant to the provisions of Part XXIX of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950, he finds that:

(a) After the change of control, the domestic insurer referred to in Subsection A of this Section would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed.

(b) The effect of the merger or other acquisition of control would be to substantially lessen competition in insurance in this state or tend to create a monopoly therein.

(c) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer or prejudice the interest of its policyholders.

(d) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets, or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest.

(e) The competence, experience, and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control.

(f) The acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

(2) The public hearing referred to in Paragraph D(1) of this Subsection shall be held within thirty days after the statement required by Subsection A of this Section is filed, and at least twenty days notice thereof shall be given by the commissioner to the person filing the statement. Not less than seven days notice of such public hearing shall be given by the person filing the statement to the insurer and to such other persons as may be designated by the commissioner. The commissioner shall make a determination within thirty days after the conclusion of such hearing. At such hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected thereby shall have the right to present evidence, examine and cross examine witnesses, and offer oral and written arguments, and in connection therewith shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in the district courts of this state. All discovery proceedings shall be concluded not later than three days prior to the commencement of the public hearing.

(3) The commissioner may retain at the acquiring person's expense, such attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the proposed acquisition of control. However, if these expenses exceed three thousand dollars, all work of these experts is subject to review, and such experts must prepare a projection of the amount of time and expenses necessary to complete the examination. If the projected amount of time and expenses required to complete the examination appear excessive, the acquiring person may request that a limit be placed on the expenses of the experts.

E. Exemptions. The provisions of this Section shall not apply to any offer, request, invitation, agreement, or acquisition which the commissioner by order shall exempt therefrom as:

(1) Not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer.

(2) Not comprehended within the purposes of this Section.

F. Violations. The following shall be violations of this Section:

(1) The failure to file any statement, amendment, or other material required to be filed pursuant to the provisions of Subsections A or B of this Section; or

(2) The effectuation or any attempt to effectuate an acquisition of control of, or merger with, a domestic insurer unless the commissioner has given his approval.

G. Jurisdiction; consent to service of process. The courts or this state are hereby vested with jurisdiction over every person not resident, domiciled, or authorized to do business in this state who files a statement with the commissioner under this Section, and over all actions involving such person arising out of violations of this Section. Each such person shall be deemed to have performed acts equivalent to and constituting an appointment by such a person of the commissioner to be his true and lawful attorney upon whom may be served all lawful process in any action, suit, or proceeding arising out of the violations of this Section. Copies of all such lawful process shall be served on the commissioner and transmitted by registered or certified mail by the commissioner to such person at his last known address.

Acts 1991, No. 794, §1; Acts 1992, No. 811, §1; Acts 1995, No. 595, §1, eff. June 18, 1995.

§1004.1. Mutual insurance holding company plan of reorganization

A. An insurer seeking to reorganize under R.S. 22:820 shall submit a proposed plan of reorganization to the commissioner. The plan shall include the following:

(1) The establishment of a mutual insurance holding company with at least one stock insurance company subsidiary, the majority of shares of which must be owned, either directly or through an intermediate stock holding company, by the mutual insurance holding company.

(2) A statement analyzing the benefits and risks attendant to the proposed reorganization, including the rationale for the reorganization.

(3) A statement indicating how the reorganization will protect the immediate and long-term interests of policyholders.

(4) A statement providing for voting rights related to the corporate affairs of the mutual insurance holding company for existing policyholders of the reorganized insurance company consistent with the voting rights of policyholders of mutual insurance companies as set forth in this Title.

(5) A statement providing for voting rights of new policyholders of the reorganized insurance company with respect to the corporate affairs of the mutual insurance holding company consistent with the voting rights of policyholders of mutual insurance companies as set forth in this Title.

(6) A statement of the number of members of the board of directors of the mutual insurance holding company, unless provided for in the articles of incorporation or bylaws, a majority of whom must be policyholders of the reorganized insurance company.

(7) A copy of the articles of incorporation and bylaws of the mutual insurance holding company, the reorganizing insurance company, and the intermediate holding company.

(8) The names, addresses, and biographical information of all corporate officers of the proposed mutual insurance holding company and the members of its board of directors in a format ordinarily required under this Part.

(9) Information sufficient to demonstrate that the financial condition of the reorganizing insurance company will not be diminished upon reorganization.

(10) A description of any plans for the initial sale of stock of the reorganizing insurance company or the intermediate holding company.

(11) Any other information requested by the commissioner, in accordance with regulations promulgated under the Administrative Procedure Act.

B. The commissioner, after a public hearing as provided in R.S. 22:1004(D), if satisfied that the interests of the policyholders are properly protected and that the plan of reorganization is fair and equitable to the policyholders, shall approve the proposed plan of reorganization and may require as a condition of approval such modifications of the proposed plan of reorganization as the commissioner finds necessary for the protection of the policyholders' interests. The commissioner may not approve a reorganization of an insurer pursuant to R.S. 22:820 unless, with respect to such reorganization, an opinion has been obtained from an actuarial firm employing or associated with more than fifty actuaries who are members of the American Academy of Actuaries attesting that the reorganization of the insurer does not unfairly enrich the officers and directors of the reorganizing insurer. The commissioner may retain consultants as provided in R.S. 22:1004(D)(3). A reorganization pursuant to R.S. 22:820 is subject to the provisions of R.S. 22:1004(A), (B), and (C).

C. The plan of reorganization shall be approved by a vote of two-thirds of the policyholders of the domestic mutual insurance company entitled to vote on matters coming before corporate meetings of the policyholders, present or represented by special ballot or special proxy, at a meeting of the policyholders convened for that purpose, after at least thirty days written notice to each policyholder at his last known address, or upon a greater percentage of vote where required by the charter of the mutual insurance company.

D. All of the initial shares of the capital stock of the reorganized insurance company shall be issued to the mutual insurance holding company or to an intermediate holding company which is a subsidiary of the mutual insurance holding company. Any membership interests of the policyholders of the reorganized insurance company shall become membership interests in the mutual insurance holding company. Policyholders of the reorganized insurance company shall be members of the mutual insurance holding company in accordance with the articles of incorporation and bylaws of the mutual insurance holding company, which shall provide that each policyholder of the reorganized insurance company shall be entitled to one vote on matters coming before corporate meetings of the mutual insurance holding company, subject to such reasonable minimum requirements as to duration of the policy and amount of insurance held as may be made in the mutual insurance holding company's charter or bylaws.

Acts 1997, No. 1482, §1.

§1004.2. Incorporation of a mutual insurance holding company

A. A mutual insurance holding company or an intermediate holding company resulting from the reorganization of a domestic mutual insurance company under R.S. 22:820 shall be incorporated pursuant to Title 12 of the Louisiana Revised Statutes of 1950, the Louisiana Business Corporation Law, R.S. 12:1 through 178, and shall be subject to its provisions and other provisions of Title 12 relative to business corporations, except that:

(1) The articles of incorporation and any amendments thereto shall be prepared in accordance with R.S. 22:32 or 38 and shall be subject to prior approval of the commissioner in the same manner as those of a domestic incorporated insurer.

(2) The articles shall be recorded and filed with the secretary of state in the same manner as the articles of a domestic incorporated insurer under R.S. 22:34.

B. The commissioner shall retain jurisdiction over a mutual insurance holding company and an intermediate holding company established pursuant to R.S. 22:820 to protect policyholders' interests, and the mutual insurance holding company shall be subject to the requirements of this Part and the Insurance Holding Company System Regulatory Law, R.S. 22:1001 et seq., to the same extent as any domestic insurer.

C. Any investments of the mutual insurance holding company, other than its investments in the intermediate holding company or the insurance company reorganized under R.S. 22:820, shall be subject to the limitations of Part XVIII of this Chapter as if the mutual insurance holding company were a domestic insurer. A mutual insurance holding company and an intermediate holding company organized under this Section shall be deemed an insurer that pays a license tax under Part XXIII of this Chapter for the purposes of R.S. 22:1069.

D. Notwithstanding anything in the Louisiana Business Corporation Law, R.S. 12:1 through 178, meetings of the mutual insurance holding company and the exercise of a member's voting rights shall be governed by R.S. 22:127 through 129 and a written proxy conferred upon another policyholder either prior to, contemporaneously with, or after a reorganization under R.S. 22:820, shall remain in force indefinitely until revoked by the member.

E. Neither the mutual insurance holding company nor any intermediate holding company shall hold a certificate of authority or engage in the business of insurance.

Acts 1997, No. 1482, §1.

§1004.3. Merger of foreign mutual insurance company

A. Subject to the prior approval of the commissioner, and upon the approval of the appropriate regulatory body in its domiciliary state either prior to or contingent upon the approval of the commissioner, a foreign mutual insurance company may reorganize by merging its policyholders' membership interests into a mutual insurance holding company established pursuant to R.S. 22:820 and continuing the corporate existence of the reorganizing foreign mutual insurance company as a foreign stock insurance company subsidiary of the mutual insurance holding company.

B. The commissioner, after a public hearing as provided in R.S. 22:1004(D), may approve the proposed merger. The commissioner may retain consultants as provided in R.S. 22:1004(D)(3). A merger pursuant to this Section is subject to R.S. 22:1004(A), (B), and (C). The reorganizing foreign mutual insurance company may remain a foreign company or foreign corporation after the merger and may be admitted to do business in this state.

C. A foreign mutual insurance company which is a party to the merger may at the same time redomesticate in this state by complying with the applicable requirements of this state and its state of domicile.

D. The provisions of R.S. 22:1004.1(D) shall apply to a merger authorized under this Section.

Acts 1997, No. 1482, §1.

§1004.4. Capital stock of a reorganized insurance company

A.(1) A mutual insurance holding company established pursuant to R.S. 22:820 shall at all times own a majority of the voting shares of the capital stock of insurance companies reorganized under R.S. 22:820.

(2) As used in this Section, "majority of the voting shares of the capital stock" means shares of the capital stock of the reorganized insurance company which carry the right to cast a majority of the votes entitled to be cast by all of the outstanding shares of the capital stock of the reorganized insurance company for the election of directors and on all other matters submitted to a vote of the shareholders of the reorganized insurance company.

(3) Ownership of a majority of the voting shares of the capital stock of the reorganized insurance company, which are required by this Section to be at all times owned by a parent mutual insurance holding company, includes indirect ownership through an intermediate holding company in a corporate structure approved by the commissioner. However, indirect ownership through an intermediate holding company shall not result in the mutual insurance holding company owning less than the equivalent of a majority of the voting shares of the capital stock of the reorganized insurance company.

B. In addition to the limitations on dividends set forth in the Insurance Holding Company System Regulatory Law, R.S. 22:1001 et seq., any dividends paid by an insurance company reorganized pursuant to R.S. 22:820 must be paid to the shareholders of record in an equal amount with respect to each issued and outstanding share, regardless of the classes of stock issued by the insurance company.

C. The majority of the voting shares of the capital stock of an insurance company reorganized under R.S. 22:820 shall not be conveyed, transferred, assigned, pledged, subjected to a security interest or lien, encumbered, or otherwise hypothecated or alienated by the mutual insurance holding company or intermediate holding company. Any conveyance, transfer, assignment, pledge, security interest, lien, encumbrance, or hypothecation or alienation of, in or on the majority of the voting shares of the reorganized insurance company which is required by this Section to be at all times owned by a mutual insurance holding company, is in violation of this Section and shall be void in inverse chronological order of the date of such conveyance, transfer, assignment, pledge, security interest, lien, encumbrance, or hypothecation or alienation, as to the shares necessary to constitute a majority of such voting shares. The majority of the voting shares of the capital stock of the reorganized insurance company which is required by this Section to be at all times owned by a mutual insurance holding company shall not be subject to execution and levy as provided in Book IV, Execution of Judgments, and Book V, Summary and Executory Proceedings, of the Louisiana Code of Civil Procedure.

D. The shares of the capital stock of the surviving or new company resulting from a merger or consolidation of two or more reorganized insurance companies or two or more intermediate holding companies which were subsidiaries of the same mutual insurance holding company are subject to the same requirements, restrictions, and limitations as provided in this Section to which the shares of the merging or consolidating reorganized insurance companies or intermediate holding companies were subject by this Section prior to the merger or consolidation.

Acts 1997, No. 1482, §1.

§1004.5. Insurer's rehabilitation and liquidation

A mutual insurance holding company established pursuant to R.S. 22:820 is deemed to be an insurer subject to Part XVI of this Chapter and shall automatically be a party to any proceeding under that Part involving an insurance company which, as a result of a reorganization pursuant to R.S. 22:820, is a subsidiary of the mutual insurance holding company or an intermediate holding company. In any proceeding under Part XVI of this Chapter involving an insurance company reorganized under R.S. 22:820, the assets of the mutual insurance holding company are deemed to be assets of the estate of the reorganized insurance company for purposes of satisfying the claims of the reorganized insurance company's policyholders. A mutual insurance holding company shall not dissolve or liquidate without the approval of the commissioner or as ordered by the district court pursuant to Part XVI of this Chapter.

Acts 1997, No. 1482, §1.

§1004.6. Applicability; membership interests

A membership interest in a domestic mutual insurance holding company established under R.S. 22:820 shall not constitute a security as defined in Part X of Chapter 2 of Title 51 of the Louisiana Revised Statutes of 1950, the Louisiana Securities Law.

Acts 1997, No. 1482, §1.

§1004.7. Sale of stock

An intermediate holding company established and an insurance company reorganized pursuant to R.S. 22:820 may issue stock to any persons legally permitted to own stock, provided that the mutual insurance holding company at all times owns either directly or indirectly a majority of the voting shares of the capital stock of the reorganized insurance company as required by R.S. 22:1004.4. Except with respect to stock issued directly or indirectly for ownership by the Mutual Insurance Holding Company, the reorganized insurance company or the intermediate holding company shall, prior to the initial issuance of stock, obtain a fairness opinion with respect to the value of the stock to be issued from an investment banking organization with experience and established credentials in the evaluation of insurance organizations. No solicitation for the sale of the stock of an insurance company reorganized under R.S. 22:820 or the intermediate holding company established under R.S. 22:820 may be made except in accordance with the provisions of R.S. 22:76.

Acts 1997, No. 1482, §1.

§1004.8. Failure to give notice

If the mutual insurance company complies substantially and in good faith with the notice requirements of R.S. 22:1004.1, the mutual insurance company's failure to give any policyholder any required notice does not impair the validity of any action taken under R.S. 22:820 or this Part.

Acts 1997, No. 1482, §1.

§1005. Registration of insurers

A. Registration.

(1) Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in:

(a) This Section.

(b) R.S. 22:1006(A), R.S. 22:1006(B).

(c) A provision such as the following: Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within fifteen days after the end of the month in which it learns of each such change or addition.

(2)(a) Any insurer which is subject to registration under this Section shall register within ninety days after it becomes subject to registration, and annually thereafter by April thirtieth of each year for the previous calendar year, unless the commissioner for good cause shown extends the time for registration, and then within such extended time.

(b) The commissioner may require any insurer authorized to do business in the state which is a member of a holding company system, and which is not subject to registration under this Section, to furnish a copy of the registration statement, the summary specified in Subsection C of this Section or other information filed by such insurance company with the insurance regulatory authority of domiciliary jurisdiction.

B. Information and form required. Every insurer subject to registration shall file the registration statement on a form prescribed by the commissioner which shall contain the following current information:

(1) The capital structure, general financial condition, ownership, and management of the insurer and any person controlling the insurer.

(2) The identity and relationship of every member of the insurance holding company system.

(3) The following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between such insurer and its affiliates:

(a) Loans, other investments, or purchases, sales, or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates.

(b) Purchases, sales, or exchange of assets.

(c) Transactions not in the ordinary course of business.

(d) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business.

(e) All management agreements, service contracts, and all cost-sharing arrangements, other than cost allocation arrangements based upon generally accepted accounting principles.

(f) Reinsurance agreements.

(g) Dividends and other distributions to shareholders.

(h) Consolidated tax allocation agreements.

(4) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the holding company system.

C. Summary of registration statement. All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

D. Materiality. No information need be disclosed on the registration statement filed pursuant to Subsection B of this Section if such information is not material for the purposes of this Section. Unless the commissioner by rule, regulation, or order provides otherwise, sales, purchases, exchanges, loans, or extensions of credit, investments, or guarantees involving one-half of one percent or less of admitted assets of the insurer as of the thirty-first day of December next preceding shall not be deemed material for purposes of this Section.

E. Reporting of dividends to shareholders. Subject to R.S. 22:1006(B), each registered insurer shall report to the commissioner all dividends and other distributions to shareholders within fifteen business days following the declaration thereof.

F. Information of insurers. Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, where such information is reasonably necessary to enable the insurer to comply with the provisions of this Part.

G. Termination of registration. The commissioner shall terminate the registration of any insurer which demonstrates it no longer is a member of an insurance holding company system.

H. Consolidated filing. The commissioner may require or allow two or more affiliated insurers subject to registration hereunder to file a consolidated registration statement.

I. Alternative registration. The commissioner may allow an insurer which is authorized to do business in this state and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under Subsection A of this Section and to file all information and material required under this Section.

J. Exemptions

(1) The provisions of this Section shall not apply to any insurer, information, or transaction if and to the extent that the commissioner by rule, regulation, or order shall exempt the same from the provisions of this Section.

(2) Unless it appears in the discretion of the commissioner that the condition of a small company renders the continuance of its business hazardous to the public or its insureds, a small company shall not be required to submit to the department a registration statement required by this Section, but shall be considered a registered insurer for the purposes of the following:

(a) Subsection E of this Section.

(b) R.S. 22:1006(A).

(c) R.S. 22:1007.

K. Disclaimer. Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer, or such a disclaimer may be filed by such insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between such person and such insurer as well as the basis for disclaiming such affiliation. After a disclaimer has been filed, the insurer shall be relieved of any duty to register or report under this Section which may arise out of the insurer's relationship with such person unless and until the commissioner disallows such a disclaimer. The commissioner shall disallow such a disclaimer only after furnishing all parties in interest with notice and opportunity to be heard and after making specific findings of fact to support such disallowance.

L. Violations. The failure to file a registration statement or any summary of the registration statement required by this Section within the time specified for such filing shall be a violation of this Section.

M. Incorporation by reference. (1) Any information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference, provided the document is filed as an exhibit to the registration statement. Any excerpt of a document may be filed as an exhibit if the document is extensive. Any documents currently on file with the commissioner which were filed within three years need not be attached as exhibits, but shall be referred to if not so attached. All references to information contained in exhibits or in documents duly filed shall clearly identify the material and specifically indicate that the material is to be incorporated by reference to the item. No materials shall be incorporated by reference in any instance that the incorporation would render the statement incomplete, unclear, or confusing.

(2) If a filing requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to the brief statement, the summary or outline may incorporate, by reference, particular parts of any exhibit or document currently on file with the commissioner which was filed within three years and may be included in its entirety by the reference. In any case where two or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties, the dates of execution, or other details, a copy of one of the documents shall be filed with a schedule identifying the omitted documents and setting forth the material details in which such documents differ from the documents filed.

Acts 1991, No. 794, §1; Acts 1992, No. 811, §1; Acts 1999, No. 1304, §1, eff. July 12, 1999; Acts 1999, No. 1312, §1, eff. July 12, 1999.

§1006. Standards and management of an insurer within a holding company system

A. Transactions within a holding company system. Transactions within a holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(1) The terms shall be fair and reasonable.

(2) Charges or fees for services performed shall be reasonable.

(3) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied.

(4) The books, accounts, and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.

(5) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(6) The following transactions, involving a domestic insurer and any person in its holding company system, shall not be entered into unless the insurer has notified the commissioner, in writing, of its intention to enter into such transaction at least thirty days prior thereto, or such shorter period as the commissioner may permit, and the commissioner has not disapproved the transaction within such period:

(a) Sales, purchases, exchanges, loans, or extensions of credit, guarantees, or investments provided such transactions are equal to or exceed:

(i) With respect to nonlife insurers, the lesser of three percent of the admitted assets of the insurer or twenty-five percent of surplus as regards policyholders;

(ii) With respect to life insurers, three percent of the admitted assets of the insurer;

each as of the thirty-first day of December next preceding.

(b) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes such loans or extensions of credit with the agreement or understanding that the proceeds of such transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, provided such transactions are equal to or exceed:

(i) With respect to nonlife insurers, the lesser of three percent of the admitted assets of the insurer or twenty-five percent of surplus as regards policyholders;

(ii) With respect to life insurers, three percent of the admitted assets of the insurer;

each as of the thirty-first day of December next preceding.

(c) All reinsurance agreements, or modifications thereto, in which the reinsurance premium, or a change in the liabilities of the insurer, equals or exceeds five percent of the surplus of the insurer as regards policyholders, as of the thirty-first day of December next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of such assets will be transferred to one or more affiliates of the insurer.

(d) All management agreements, service contracts, and all cost-sharing arrangements, other than cost-sharing arrangements based upon generally accepted accounting principles.

(e) Any material transactions, specified by regulation, which the commissioner determines may adversely affect the interests of the policyholders of the insurer.

(7) A domestic insurer shall not enter into transactions, which are part of a plan or series of similar transactions, with persons within the holding company system, if the purpose of the separate transactions is the avoidance of the statutory threshold amount and thus avoid the review that would occur otherwise. If the commissioner determines that the separate transactions were entered into over any twelve-month period for such purpose, he may exercise his authority under R.S. 22:1011.

(8) The commissioner, in reviewing transactions pursuant to Paragraph (6) of this Subsection shall consider whether the transactions comply with the standards set forth in Paragraphs (1) through (5) of this Subsection and whether they may adversely affect the interest of policyholders.

(9) The commissioner shall be notified, within thirty days, of any investment of the domestic insurer in any one corporation if the total investment in such corporation by the insurance holding company system exceeds ten percent of the voting securities of the corporation.

B. Dividends and other distributions.

(1) No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until:

(a) Thirty days after the commissioner has received notice of the declaration thereof and has not within such period disapproved such payment.

(b) The commissioner shall have approved such payment within such thirty-day period.

(2)(a) For purposes of this Section, until October 30, 1993, an extraordinary dividend or distribution shall include any dividend or distribution of cash or other property, whose fair market value, together with that of other dividends or distributions made within the preceding twelve months, exceeds the greater of:

(i) Ten percent of the surplus of the insurer as regards policyholders as of the thirty-first day of December next preceding; or

(ii) The net gain from operations of such insurer, if such insurer is a life insurer, or the net income, if such insurer is not a life insurer, not including realized capital gains, for the twelve-month period ending the thirty-first day of December next preceding, but shall not include pro rata distributions of any class of the insurer's own securities.

(b) In determining whether a dividend or distribution is extraordinary, an insurer, other than a life insurer, may carry forward net income from the previous two calendar years that has not already been paid out as dividends. The carry forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years. Effective October 30, 1993, any extraordinary dividend or distribution shall include any dividend or distribution of cash or other property whose fair market value, together with that of other dividends or distributions made within the preceding twelve months, exceeds the lesser of (i) or (ii) of Subparagraph (a).

(3) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval thereof, and such a declaration shall confer no rights upon shareholders until:

(a) The commissioner has approved the payment of such a dividend or distribution.

(b) The commissioner has not disapproved such payment within the thirty-day period referred to above.

C. Adequacy of surplus. For purposes of this Part, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria.

(2) The extent to which the insurer's business is diversified among the several lines of insurance.

(3) The number and size of risks insured in each line of business.

(4) The extent of the geographical dispersion of the insurer's insured risks.

(5) The nature and extent of the insurer's reinsurance program.

(6) The quality, diversification, and liquidity of the insurer's investment portfolio.

(7) The recent past and projected future trend in the size of the insurer's investment portfolio.

(8) The surplus as regards policyholders maintained by other comparable insurers.

(9) The adequacy of the insurer's reserves.

(10) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in his judgment such investment so warrants.

Acts 1991, No. 794, §1; Acts 1992, No. 811, §1.

§1007. Examination

A. Power of commissioner. Subject to the limitation contained in this Section and in addition to the powers which the commissioner has under this Code relating to the examination of insurers, the commissioner shall also have the power to order any insurer registered under R.S. 22:1005 to produce such records, books, or other information papers in the possession of the insurer or its affiliates as are reasonably necessary to ascertain the financial condition of such insurer or to determine compliance with this Part. In the event such insurer fails to comply with such order, the commissioner shall have the power to examine such affiliates to obtain such information.

B. Use of consultants. The commissioner may retain at the registered insurer's expense, such attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff as shall be reasonably necessary to assist in the conduct of the examination under Subsection A of this Section. Any persons so retained shall be under the direction and control of the commissioner and shall act in a purely advisory capacity. However, if these expenses exceed three thousand dollars, all work of these experts is subject to review, and such experts must prepare a projection of the amount of time and expenses necessary to complete the examination. If the projected amount of time and expenses required to complete the examination appear excessive, the registered insurer may request a limit be placed on the expenses of the expert.

C. Expenses. Each registered insurer producing for examination records, books, and papers pursuant to Subsection A of this Section shall be liable for and shall pay the expense of such examination in accordance with R.S. 22:1304 through 1306.

Acts 1991, No. 794, §1; Acts 1992, No. 811, §1.

§1008. Confidential treatment

All information, documents and copies thereof obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to R.S. 22:1007, and all information reported pursuant to R.S. 22:1004 through R.S. 22:1006, shall be given confidential treatment, shall not be subject to subpoena, and shall not be made public by the commissioner, the National Association of Insurance Commissioners, or any other person, except to insurance departments of other states.

Acts 1991, No. 794, §1.

§1009. Rules and regulations

The commissioner may, upon notice and opportunity for all interested persons to be heard, issue such rules, regulations, and orders as shall be necessary to carry out the provisions of this Part.

Acts 1991, No. 794, §1.

§1010. Injunctions, prohibitions against voting securities, sequestration of voting securities

A. Injunctions. Whenever it appears to the commissioner that any insurer or any director, officer, employee, or agent thereof has committed or is about to commit a violation of this Part or of any rule, regulation, or order issued by the commissioner hereunder, the commissioner may apply to the Nineteenth Judicial District Court in and for the parish of East Baton Rouge for an order enjoining such insurer or such director, officer, employee, or agent thereof from violating or continuing to violate this Part or any such rule, regulation, or order, and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors, and shareholders, or the public may require.

B. Voting of securities; when prohibited.

(1) No security which is the subject of any agreement or arrangement regarding acquisition, or which is acquired or to be acquired, in contravention of the provisions of this Part or of any rule, regulation, or order issued by the commissioner hereunder shall be voted at any shareholder's meeting, or shall be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though such securities were not issued and outstanding, but no action taken at any such meeting shall be invalidated by the voting of such securities, unless the action would materially affect control of the insurer or unless the courts of this state have so ordered.

(2) If an insurer or the commissioner has reason to believe that any security of the insurer has been or is about to be acquired in contravention of the provisions of this Part or of any rule, regulation, or order issued by the commissioner hereunder, the insurer or the commissioner may apply to the Nineteenth Judicial District Court in and for the parish of East Baton Rouge to enjoin any offer, request, invitation, agreement, or acquisition made in contravention of any rule, regulation, or order issued by the commissioner thereunder to enjoin the voting of any security so acquired, to avoid any vote of such security already cast at any meeting of shareholders, and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors, and shareholders or the public may require.

C. Sequestration of voting securities. In any case where a person has acquired or is proposing to acquire any voting securities in violation of this Part or any rule, regulation, or order issued by the commissioner hereunder, the Nineteenth Judicial District Court in and for the parish of East Baton Rouge may, on such notice as the court deems appropriate, upon the application of the insurer or the commissioner, seize or sequester any voting securities of the insurer owned directly or indirectly by such person, and issue such order with respect thereto as may be appropriate to effectuate the provisions of this Part.

D. Site of ownership. Notwithstanding any other provisions of law, for the purposes of this Part the sites of the ownership of the securities of domestic insurers shall be deemed to be in this state.

Acts 1991, No. 794, §1.

§1011. Sanctions

A. Any insurer failing, without just cause, to file a registration statement as required in this Part shall be required, after notice and hearing, to pay a penalty of one hundred dollars for each day's delay, to be recovered by the commissioner, and the penalty so recovered shall be paid into the general revenue fund of this state. The maximum penalty under this Section shall be ten thousand dollars. The commissioner may reduce the penalty if the insurer demonstrates that the imposition of the penalty would constitute a financial hardship to the insurer.

B. Every director or officer of an insurance holding company system who knowingly violates, participates in, or assents to, or who knowingly permits any of the officers or agents of the insurer to engage in transactions or make investments which have not been properly reported or which violate this Part, shall pay, in their individual capacities, a civil forfeiture of not more than one thousand dollars per violation, after notice and hearing before the commissioner.

In determining the amount of the civil forfeiture, the commissioner shall take into account the appropriateness of the forfeiture with respect to the gravity of the violation, the history of previous violations, and such other matters as justice may require.

C. Whenever it appears to the commissioner that any insurer subject to this Part or any director, officer, employee, or agent thereof has engaged in any transaction or entered into a contract which violates this Part, the commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing, the commissioner may also, order the insurer to void any such contracts and restore the status quo if such action is in the best interest of the policyholders, creditors, or the public.

D. Any officer, director, or employee of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made any false statements or false reports or false filings with the intent to deceive the commissioner in the performance of his duties under this Part, upon conviction thereof shall be imprisoned with or without hard labor for not more than five years or fined not more than fifty thousand dollars or both. Any fines imposed shall be paid by the officer, director, or employee in his individual capacity.

Acts 1991, No. 794, §1; Acts 1992, No. 1116, §1.

§1012. Receivership

Whenever it appears to the commissioner that any person has committed a violation of this Part which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders, or the public, then the commissioner may proceed as provided in Part XVI of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950.

Acts 1991, No. 794, §1.

§1013. Recovery

A. If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer:

(1) From any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions, other than distributions of shares of the same class of stock, paid by the insurer on its capital stock; or

(2) Any payment in the form of a bonus, termination settlement, or extraordinary lump sum salary adjustment made by the insurer or its subsidiary to a director, officer, or employee, where the distribution or payment pursuant to (1) or (2) herein is made at any time during the one year preceding the petition for liquidation, conservation, or rehabilitation, as the case may be, subject to the limitations of Subsections B, C, and D of this Section.

B. No distribution shall be recoverable if the parent or affiliate shows that such distribution was lawful and reasonable when paid, and that the insurer did not know and could not reasonably have known that such distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

C. Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time such distributions were paid shall be liable up to the amount of distributions or payments the person received under Subsection A of this Section. Any person who otherwise controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions he would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be solidarily obligated.

D. The maximum amount recoverable under this Subsection shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

E. To the extent that any person liable under Subsection C of this Section is insolvent or otherwise fails to pay claims due from it pursuant to such Subsection, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid, shall be solidarily obligated for any resulting deficiency in the amount recovered from such parent corporation or holding company or person who otherwise controlled it.

Acts 1991, No. 794, §1.

§1014. Revocation, suspension, or nonrenewal of insurer's license

Whenever it appears to the commissioner that any person has committed a violation of this Part which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the commissioner may, after giving notice and an opportunity to be heard, determine to suspend, revoke, or refuse to renew such insurer's license or authority to do business in this state for such period as he finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law.

Acts 1991, No. 794, §1.

§1015. Judicial review; mandamus

A. Any person aggrieved by any act, determination, rule, regulation, or order, or any other action of the commissioner pursuant to this Part, may appeal therefrom to the Nineteenth Judicial District Court in and for the parish of East Baton Rouge. The court shall conduct its review without a jury and by trial de novo, except that if all parties, including the commissioner, so stipulate, the review shall be confined to the record. Portions of the record may be introduced by stipulation into evidence in a trial de novo as to those parts so stipulated.

B. The filing of an appeal pursuant to this Section shall stay the application of any such rule, regulation, order, or other action of the commissioner to the appealing party unless the court, after giving such party notice and an opportunity to be heard, determines that such a stay would be detrimental to the interest of policyholders, shareholders, creditors, or the public.

C. Any person aggrieved by any failure of the commissioner to act or make a determination required by this Part may petition the Nineteenth Judicial District Court in and for the parish of East Baton Rouge for a writ in the nature of a mandamus or a peremptory mandamus directing the commissioner to act or make such determination forthwith.

Acts 1991, No. 794, §1.

PART XXII. DEPOSITS

§1021. General deposit; foreign and alien insurers

All foreign or alien insurers doing business in this state shall, subject to the exceptions contained in R.S. 22:1023 and 1024, deposit with the commissioner of insurance a safekeeping or trust receipt from a bank doing business within the state or from a savings and loan association chartered to do business in this state indicating that twenty thousand dollars in money or in approved bonds of the United States, the state of Louisiana, or any political subdivision thereof, of the market value of not less than twenty thousand dollars has been made. Such approval shall be made by the commissioner of insurance.

Acts 1958, No. 125. Amended by Acts 1969, No. 75, §1; Acts 1979, No. 198, §1; Acts 1979, No. 235, §1; Acts 1981, No. 746, §1; Acts 1982, No. 748, §1; Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996.

§1022. Condition of deposit

The above deposit shall be conditioned only for, and dedicated exclusively to, the prompt payment of all claims arising and accruing to any person by virtue of any policy issued by any such insurer upon the life or person of any citizen of the state of Louisiana, or upon any property or other risk situated in this state. Under no circumstances shall such deposit be used for the payment of any fee whatsoever to any attorney, agent, or other person appointed for any services rendered in connection with any ancillary conservation, ancillary receivership, or any other supervisory proceeding or mode involving the company making such deposit.

Acts 1958, No. 125. Amended by Acts 1979, No. 81, §1, eff. June 29, 1979.

§1023. Surety bond in lieu of deposit

In lieu of deposit required by R.S. 22:1021, such insurers may deliver to the commissioner of insurance a bond in the amount of one hundred thousand dollars of an authorized surety company doing business in this state which has a minimum surplus of five million dollars and approved by the commissioner of insurance. The bond shall be conditioned on the same terms as those stated in R.S. 22:1022 and it must be renewed annually before the first of March. No such bond shall be cancelled unless a new bond or deposit has been substituted or satisfactory evidence has been submitted to the commissioner of insurance that the insurer has discharged all of its assured obligations and liabilities in this state, and that insurer has no assured liabilities whatever remaining in this state. The term of these bonds shall be for one year ending the first of March, but the last bond filed shall always remain in effect until a new bond is filed or a deposit is made as a substitution therefor.

Acts 1958, No. 125. Amended by Acts 1979, No. 198, §2; Acts 1981, No. 540, §1.

§1024. Exception; life insurer

Any life insurer having and maintaining one hundred thousand dollars unimpaired capital stock, if a stock company, or one hundred thousand dollars surplus above all liabilities if a mutual company, and maintaining one hundred thousand dollars in approved securities on deposit with the proper official of its home state, or state of entry if an alien insurer, or with its proper territorial officer if domiciled in a United States territory to secure the payment of any policy claim need not comply with the provisions of R.S. 22:1021 or 22:1023.

Acts 1958, No. 125.

§1025. Additional deposit; surety insurer

All domestic, foreign, or alien insurers engaged in doing a guaranty, fidelity, surety, or bond business in this state shall, in addition to the other deposit requirements of this Part, deposit with the commissioner of insurance of this state a safekeeping or trust receipt from a bank doing business within the state or from a savings and loan association chartered to do business in this state indicating that a deposit has been made in the sum of fifty thousand dollars in money, or bonds of the United States or the state of Louisiana, or of any political subdivision thereof of the par value of not less than fifty thousand dollars, said bonds to be subject to the approval of the commissioner of insurance, and the value of said deposit shall be maintained.

Acts 1958, No. 125. Amended by Acts 1969, No. 76, §1; Acts 1979, No. 151, §1; Acts 1979, No. 235, §1; Acts 1981, No. 660, §1; Acts 1982, No. 748, §1.

§1026. Conditions of additional deposit

The deposit required in R.S. 22:1025 shall be held subject to any claims, liens or judgments that may be judicially obtained against any such company in the courts of this state, or arising from any contract of insurance, or indemnity, or fidelity, or guaranty entered into in this state, and shall be liable to seizure and sale at the instance of any judgment creditor of such insurer, under judgment obtained in any of the courts of this state or in any of the federal courts in this state.

Acts 1958, No. 125.

§1027. Withdrawals

Withdrawal of any bond or deposit required by R.S. 22:1021, 22:1023, or 22:1025 may be made only upon approval by the commissioner of insurance and in accordance with the provisions of R.S. 22:991.

Acts 1958, No. 125.

§1028. Deposit required of domestic insurers

All domestic insurers, except those having other specific deposit requirements stated in this Code, shall, before receiving a certificate of authority, deposit with the commissioner of insurance a safekeeping or trust receipt from a bank doing business within the state or from a savings and loan association chartered to do business in this state indicating that the insurer has deposited one hundred thousand dollars in money, or bonds of the United States, the state of Louisiana, or any political subdivision thereof, of the par value of not less than one hundred thousand dollars or of a value equal to the minimum capital or initial minimum surplus required in order to transact its business, whichever is less. All securities deposited pursuant to this Section shall be held in trust for the benefit and protection of and as security for all policyholders and creditors of the insurer making such deposit.

Acts 1958, No. 125. Amended by Acts 1969, No. 77, §1; Acts 1979, No. 235, §1; Acts 1981, No. 672, §1; Acts 1982, No. 748, §1.

§1029. Registered policies; deposit

A. Any domestic life insurer and any foreign or alien life insurer doing business in this state, may annually deposit with the commissioner of insurance for the common benefit of its life, annuity, and endowment policies or any separate class or special kind thereof, securities including evidence of ownership of real estate of the kinds in which, by the laws of this state, it is permitted to invest or loan its funds, equal to the legal reserve on all such outstanding policies in force, including also all funds held in trust for deferred or installment payments, as shown by its last annual statement to the commissioner of insurance, as required by law, which securities shall be held by the commissioner of insurance in trust for the purposes and objects herein specified. For the purpose of this Section, the securities hereinabove referred to shall include trust receipts or certificates of deposit, with right to substitution, issued by any depository bank in this state or any savings and loan association chartered to do business in this state which has been selected by the insurer with the approval of the commissioner of insurance, as trustee of the kinds of securities in which the insurer may invest in accordance with R.S. 22:841 through R.S. 22:853. The commissioner of insurance may cause any such securities to be appraised and valued prior to their being deposited with, or conveyed to, the commissioner of insurance in trust as aforesaid, the reasonable expense of such appraisement or valuation to be paid by the insurer. Insofar as any depository bank, which issues such trust receipts or certificates of the deposit of such securities shall be concerned, the certificates of the insurer as to the value and validity of such securities shall be conclusive.

B. After making said deposit any insurer may thereafter issue life, annuity or endowment policies, of the class designated, which shall have upon their face a certificate substantially in the following words:

"STATE OF LOUISIANA . . . I, the undersigned Commissioner of Insurance of Louisiana, do hereby certify that the . . . Company invests and maintains in stipulated securities as required by the law of the State of Louisiana its fully paid up capital, together with the net cash value of every outstanding policy; and said company has on deposit with the commissioner of insurance of Louisiana such stipulated securities equal in amount to such net cash value of all outstanding policies as shown by its last annual statement, which fund the law requires the company to maintain during the continuance of this policy."

C. Any insurer making deposits under the provisions of this Section, may at its option, withdraw from the provisions of this Section by ceasing to issue such certified policies. Any insurer withdrawing from the depository requirement after accepting the terms of this Section, shall be required to continue to maintain the deposits herein required on all funds held in trust for deferred or installment payments on policies certified by the commissioner of insurance, and likewise to maintain the deposits on all policies certified by the commissioner of insurance. Whenever any insurer shall cease to issue certified policies it shall notify the commissioner of insurance in writing; and at the same time it shall report under oath by its president and secretary to the commissioner of insurance the amount or value of outstanding certified policies and the amount on deposit with the commissioner of insurance, and such amount on deposit shall be made to equal the said value of said outstanding policies; and annually thereafter said insurer shall keep on deposit with the commissioner of insurance an amount sufficient to equal the value of said outstanding policies as shown by the annual statement of the insurer, and shall report such fact to the commissioner of insurance under oath in such form as the commissioner may require. As such certified policies are commuted or terminated the amount on deposit with the commissioner of insurance may be reduced and withdrawn by the insurer semiannually upon presentation of proof under oath of its officers of the amount of commutations or terminations, upon approval of the commissioner of insurance.

D. The securities deposited under this Section by each insurer shall be placed with a bank in this state or a savings and loan association chartered to do business in this state and the safekeeping or trust receipt kept by the commissioner of insurance in some secure safe deposit, fireproof box or vault, and no officer or employee of the insurer shall have access thereto. The state of Louisiana obligates itself to safely keep all safekeeping or trust receipts or other securities held in trust by the commissioner of insurance under this Section. The bank in this state or the savings and loan association chartered to do business in this state, which has issued a safekeeping or trust receipt, shall detach and deliver to the insurer all interest coupons as they accrue. The insurer shall have the right to collect such interest as it shall accrue.

E. The certificate of the commissioner of insurance herein provided for may be printed on the face of policies issued but only when such certificate has been annually renewed and issued to any insurer by the commissioner of insurance, and is on file in the home office of the insurer.

Acts 1958, No. 125. Amended by Acts 1979, No. 235, §1; Acts 1981, No. 672, §1; Acts 1982, No. 748, §1.

§1030. REPEALED BY ACTS 1979, No. 235, §2

PART XXIII. TAXES AND FEES

§1061. Imposition of tax; exceptions

A. There is hereby levied an annual license tax for the year 1982, and for each subsequent year, on each domestic, foreign, and alien insurer engaged in the business of issuing insurance policies, contracts, or obligations; issuing endowment policies; or similar forms of contract obligations in consideration of the payment of a premium or other consideration for the issuance of such policies, contracts, or obligations, whether such insurer be operating in this state through an agent, other representative, or otherwise. Such license shall be fixed and graded according to the rates and classifications set forth in this Part and shall be based on the gross amount of annual premiums on all risks, except annuity contracts, located in this state and, in the case of insurance and endowment policies, contracts, or obligations, upon the gross amount of annual premiums on such policies issued to persons located in Louisiana, without deduction for dividends paid or credited to policyholders.

B. The life insurance programs administered by the Office of Group Benefits as authorized and provided for pursuant to the provisions of Part II of Chapter 12 of Title 42 of the Louisiana Revised Statutes of 1950, R.S. 42:821 et seq., shall be exempt and excepted from the payment of the annual license tax levied by the provisions of this Section.

Acts 1958, No. 125. Amended by Acts 1982, No. 868, §1, eff. Jan. 1, 1982; Acts 1989, No. 656, §1; Acts 2001, No. 1178, §2, eff. June 29, 2001.

§1062. Life, accident, health, or service insurance

A. Upon the business of issuing life, accident, health, or service insurance policies, or other forms of contracts or obligations covering such risks, or issuing endowment policies on contracts, or other similar forms of contract obligations, the minimum annual license tax shall be one hundred forty dollars when the gross annual premiums are seven thousand dollars or less. When the gross annual premiums are more than seven thousand dollars, the amount of license tax payable shall be increased to two hundred twenty-five dollars for each additional ten thousand dollars, or fraction thereof, of gross annual premiums. The business of issuing each of the kinds of insurance or contracts mentioned in this Section may be combined under one license tax, and the amount of the license tax shall be based on the combined gross annual premiums of all such businesses.

B. For the year 1984 the amount of license tax payable pursuant to this Section shall be based on the rate in effect at the time the premiums were collected; that is, for 1984 the minimum annual license tax shall be one hundred forty dollars when the gross annual premiums are seven thousand dollars or less; when the gross annual premiums are more than seven thousand dollars, the amount of the license tax payable shall be increased to one hundred seventy dollars for each additional ten thousand dollars, or fraction thereof, of gross premiums collected prior to July 1, 1984 and shall be increased to two hundred twenty-five dollars for each additional ten thousand dollars, or fraction thereof, of gross premiums collected on or after July 1, 1984.

Acts 1984, 1st Ex. Sess., No. 3, §1, eff. March 27, 1984.

{{**NOTE:** SEE ACTS 1984, 1ST EX. SESS., NO. 3, §2.}}

§§1063. – §1064. REPEALED BY ACTS 1974, No. 42, §1

§1065. Fire, marine, transportation, casualty, surety, or other insurance

A.(1) Upon the business of issuing policies, contracts, or other forms of obligations covering the risk of fire, marine, transportation, surety, fidelity, indemnity, guaranty, workers' compensation, employers' liability, property damages, livestock, vehicle, automatic sprinkler, burglary, or insurance of any other kind whatsoever in this state not otherwise provided for in this Part, the minimum annual license tax shall be one hundred eighty-five dollars when the gross annual premiums shall be six thousand dollars or less; and when the gross annual premiums shall be more than six thousand dollars, the amount of license tax payable shall be increased to three hundred dollars for each additional ten thousand dollars, or fraction thereof, of gross annual premiums. The business of issuing each of the kinds of insurance or contracts mentioned in this Section may be combined under one license tax, and the amount of the license tax shall be based on the combined gross annual premiums of all such businesses.

(2)(a) After June 30, 2002, this tax shall be paid on a quarterly basis; however, the first payment shall include the amount which would have been paid in previous quarters of 2002 had the increase provided by Acts 2002, No. 83, been in effect as of January 1, 2002.

(b) There is hereby created in the state treasury the Risk Management Insurance Premium Payment Fund. The treasurer shall deposit into the Risk Management Insurance Premium Payment Fund, five million seven hundred fifty thousand dollars from taxes collected under the provisions of this Section in Fiscal Year 2001-2002 that are in excess of actual collections under the provisions of this Section in Fiscal Year 2000-2001, after first having credited such tax collections to the Bond Security and Redemption Fund as required by Article VII, Section 9(B) of the Louisiana Constitution. Monies in the Risk Management Insurance Premium Payment Fund shall be used solely for the purpose of paying premiums to the Office of Risk Management as determined by the legislature through appropriation.

(c)(i) There is hereby created in the state treasury the Excess Revenue Collection Fund. The treasurer shall deposit into the Excess Revenue Collection Fund any taxes collected under the provisions of this Section in Fiscal Year 2001-2002, in excess of actual collections under the provisions of this Section in Fiscal Year 2000-2001, after first having been credited to the Bond Security and Redemption Fund as required by Article VII, Section 9(B) of the Louisiana Constitution, amounts as provided in Items (ii) and (iii) of this Subparagraph. Monies in the Excess Revenue Collection Fund shall be used in amounts appropriated by the legislature solely for the purpose of meeting any increase in employer contributions required over and above the statutory minimum set forth in R.S. 11:103(C)(2)(b)(i) for the fiscal year beginning July 1, 2002, for employer contributions of the Firefighters' Retirement System notwithstanding the rate as established by the Public Retirement Systems Actuarial Committee for Fiscal Year 2002-2003. These funds shall be applied on a monthly basis until such appropriation is exhausted, after which direct employer contributions shall be made at the rate set by the Public Retirement Systems Actuarial Committee.

(ii) Four million five hundred thousand dollars shall be deposited in the Excess Revenue Collection Fund after satisfying the requirements of Subparagraph (b) of this Paragraph.

(iii) An amount not to exceed four million five hundred thirty-six thousand dollars shall be deposited in the Excess Revenue Collection Fund after satisfying the requirements of Item (ii) of this Subparagraph; provided that this allocation shall only be made if actual collections from taxes, licenses, and fees from all sources comprising the Official Forecast for Fiscal Year 2001-2002 exceed the Official Forecast for Fiscal Year 2001-2002 adopted by the Revenue Estimating Conference on April 30, 2002, and only if actual collections exceed the forecast by the amount deposited as required by this Item.

(d) There is hereby created in the state treasury the Louisiana State Police Salary Fund. Monies in the Louisiana State Police Salary Fund shall be used in amounts appropriated by the legislature to cover the cost of salary increases and related benefits for members of the state police service. Taxes collected under the provisions of this Section in Fiscal Year 2002-2003 and ensuing fiscal years that are in excess of total collections under the provisions of this Section in Fiscal Year 2000-2001, after first having been credited to the Bond Security and Redemption Fund as required by Article VII, Section 9(B) of the Louisiana Constitution, shall be deposited into the Louisiana State Police Salary Fund until the amount deposited in each fiscal year is equal to fifteen million six hundred thousand dollars.

(e) The provisions of Subparagraphs (b) and (c) of this Paragraph shall be null, void, and of no effect after July 1, 2003.

B. For the year 1984 the amount of the license tax payable pursuant to this Section shall be based on the rate in effect at the time the premiums were collected; that is, for 1984 the minimum annual license tax shall be one hundred eighty dollars when the gross annual premiums are six thousand dollars or less; when the gross annual premiums are more than six thousand dollars, the amount of license tax payable shall be increased to one hundred eighty-five dollars for each additional ten thousand dollars, or fraction thereof, of gross premiums collected before July 1, 1984 and shall be increased to three hundred dollars for each additional ten thousand dollars, or fraction thereof, of gross premiums collected on or after July 1, 1984.

Acts 1984, 1st. Ex. Sess., No. 3, §1, eff. March 27, 1984; Acts 2002, No. 83, §1, eff. June 30, 2002.

{{**NOTE**: SEE ACTS 1984, 1ST EX. SESS., NO. 3, §2.}}

§1065.1. Criminal bail bond annual license fee

A. There shall be a fee on premiums for all commercial surety underwriters who write criminal bail bonds in the state of Louisiana, as follows:

(1) Except in the parish of Orleans, the fee shall be equal to two dollars for each one hundred dollars worth of liability underwritten by the commercial surety. Except as authorized under the provisions of R.S. 13:718(I)(2), this shall be the exclusive fee or tax on any criminal bail bond premium, including thereto premium taxes owed. In furtherance of the payment of this premium fee all commercial surety underwriters underwriting criminal bail bonds in the state of Louisiana shall, upon submitting the appearance bond and their power of attorney, simultaneously pay to the sheriff of the parish, except in the parish of Orleans, a fee of two dollars for each one hundred dollars worth of liability on the bail bond being presented for the release of a person on bail. Failure to pay the fee shall prevent the sheriff from accepting the appearance bond and power of attorney. The sheriff may receive the fee by check or cash and shall only accept it from the surety or the agent of the surety. In the event a surety or agent of the surety presents payment of the fee by an instrument which is returned for insufficient funds, the agent or the agent of the surety shall be prevented from presenting the appearance bonds with their power of attorney attached until the outstanding fees are paid to the sheriff.

(2) In the parish of Orleans, the fee shall be equal to three dollars for each one hundred dollars worth of liability underwritten by the commercial surety. This shall be the exclusive fee or tax on any criminal bail bond premium, including thereto premium taxes owed. In furtherance of the payment of this premium fee, all commercial surety underwriters underwriting criminal bail bonds in the parish of Orleans shall, upon submitting the appearance bond and their power of attorney, simultaneously pay to the sheriff a fee of five dollars for each one hundred dollars worth of liability on the bail bond being presented for the release of a person on bail. Failure to pay the fee shall prevent the sheriff from accepting the appearance bond and power of attorney. The sheriff may receive the fee by check or cash and shall only accept it from the surety or the agent of the surety. In the event a surety or agent of the surety presents payment of the fee by an instrument which is returned for insufficient funds, the agent or the agent of the surety shall be prevented from presenting the appearance bonds with their power of attorney attached until the outstanding fees are paid to the sheriff.

B.(1)Except as otherwise provided in this Subsection, all premium fees collected by the sheriff shall be remitted within sixty days after receipt as follows:

(a) Twenty-five percent to the judicial court fund or its equivalent.

(b) Twenty-five percent to the sheriff's general fund.

(c) Twenty-five percent to the district attorney's operating fund.

(d) Twenty-five percent to the Indigent Defenders Program.

(2) In the Twenty-Second Judicial District, all premium fees collected by the sheriff shall be remitted within sixty days after receipt as follows:

(a) Twenty-two percent to the judicial court fund or its equivalent.

(b) Twenty-two percent to the sheriff's general fund.

(c) Twenty-two percent to the district attorney's operating fund.

(d) Twenty-two percent to the Indigent Defenders Program.

(e) Twelve percent to the St. Tammany Children's Advocacy Center.

(3) In Orleans Parish, two dollars of the three dollars collected for each one hundred dollars worth of liability underwritten by the commercial surety on all premium fees collected by the sheriff shall be maintained, supervised, and distributed as provided in R.S. 13:1381.5 and the one additional dollar of the three dollars collected for each one hundred dollars worth of liability underwritten by the commercial surety shall be allocated to the Criminal District Court for the Parish of Orleans.

Acts 1993, No. 834, §5, eff. June 22, 1993; Acts 1999, No. 1080, §1; No. 717, §2; Acts 2000, 1st Ex. Sess., No. 113, §1; Acts 2001, No. 928, §2, eff. June 26, 2001; Acts 2005, No. 350, §1.

§1066. Tax base; computation in case of new business

The annual premiums referred to in this Part shall be the gross amount of direct premiums, excluding premiums on annuity contracts, for the preceding year less return premiums without any deductions for dividends paid or otherwise credited to policyholders, and without consideration for reinsurance.

Acts 1958, No. 125. Amended by Acts 1982, No. 868, §1, eff. Jan. 1, 1982.

§1067. Tax for insurer commencing business after first of January; tax for insurer withdrawing

A. Any insurer commencing business after the first of January of any year shall pay the minimum license tax as provided in the preceding sections of this Part for the privilege of doing business until its annual statement for that year is filed. In the event it collected premiums taxable under the provisions of this Part during the preceding calendar year, the tax shall be based upon such premiums, but shall never be less than the minimum.

B. On or before March 1st of the following year, the tax for the preceding year shall be computed as provided in this Part, except that upon the filing of the annual statement for the year in which it commenced business a new insurer shall be permitted to take credit for the minimum tax paid by it under Subsection A of this Section if the tax is in excess of the minimum. In no event, however, shall the tax be less than the minimum.

C. In the event of withdrawal of a foreign or alien insurer, as provided in R.S. 22:991, at year end, the license tax for the preceding year shall be due and payable within sixty days. In the event of withdrawal of a foreign or alien insurer at other than year end, the license tax based on premiums collected for that portion of the year in which it transacted business up to the date of withdrawal shall be due and payable within sixty days, but in no event shall the tax for the withdrawing insurer be less than the minimum license tax as provided in this Part.

Acts 1958, No. 125. Acts 1966, No. 173, §1. Acts 1983, 1st Ex. Sess., No. 16, §1, eff. Jan. 19, 1983.

§1068. Reduction of tax when certain investments are made in Louisiana

A. The amount of the license payable shall be reduced from the amount otherwise fixed in this Part if the payer files a sworn statement with the annual report required by this Part showing as of December 31 of the reporting period that at least the following amounts of the total admitted assets of the payer, less assets in an amount equal to the reserves on its policies issued in foreign countries in which it is authorized to do business and which countries require an investment therein as a condition of doing business, are invested and maintained in qualifying Louisiana investments as hereinafter defined in Subsection C.

B. If one-sixth of the total admitted assets of the payer are in qualifying Louisiana investments, then the license payable shall be thirty-three and one-third percent of the amount otherwise fixed in this Part; if at least one-fifth of the total admitted assets of the payer are in qualifying Louisiana investments, then the license payable shall be twenty-five percent of the amount otherwise fixed in this Part; if at least one-fourth of the total admitted assets of the payer are in qualifying Louisiana investments, the license payable shall be fifteen percent of the amount otherwise fixed in this Part; and if at least one-third of the total admitted assets of the payer are in qualifying Louisiana investments, then the license payable shall be five percent of the amount otherwise fixed in this Part.

C. For the purposes of this Part, "a qualifying Louisiana investment" is hereby defined as:

(a) Certificates of deposit issued by any bank or savings and loan association domiciled in this state, or certificates of deposit issued by any limited function financial institution domiciled in this state;

(b) Bonds of this state or bonds of municipal, school, road, or levee districts, or other political subdivisions of this state or bonds approved for issue by the Louisiana State Bond Commission;

(c) Mortgages on property located in this state;

(d) Real property located in this state;

(e) Policy loans to residents of Louisiana, or other loans to residents of this state, or to corporations domiciled in this state;

(f) Common or preferred stock in corporations domiciled in this state; and

(g) Cash on deposit in any bank or savings and loan association domiciled in this state.

D. Recognizing that it is in the public interest to create an incentive for environmentally clean industry to locate in this state and to broaden the economic base; to encourage investment in this state; and to enhance the economic and financial climate of the state, the legislature finds that a premium tax reduction for insurers investing in certain qualified Louisiana assets promotes the public interest.

E.(1)(a) Recognizing that it is also in the public interest to ensure sufficient availability of venture capital for purposes of technological development and job creation, the premium tax reduction for insurers investing in certified capital companies as defined in R.S. 51:1921 et seq., or in industrial or economic development corporations as defined in R.S. 12:951 et seq., shall be computed as one hundred percent of the amount of the investment at the time the investment is made. The premium tax reduction shall be available for, but not limited to, taxes charged on insurance premiums under R.S. 22:1061, 1062, 1065, 1079, and 1265. Notwithstanding any provision of law to the contrary, the premium tax reduction shall not be available for taxes charged on insurance premiums under R.S. 22:1076, 1076.1, 1077, 1080, 1419, and 1583. The investment shall be in the form of cash or debt instruments that are obligations of the investing insurance company to the certified capital company or the industrial or economic development corporation. Such debt instruments shall be converted into cash at a rate of not less than ten percent per year from the date of the investment.

(b) For purposes of this Subsection, the term "investment" shall include the investment of cash or a note by an insurance company in exchange for either (i) equity in a certified Louisiana capital company or (ii) a loan receivable from a certified Louisiana capital company which has a stated final maturity date of not less than five years from the origination date of the loan and shall not be repaid in a manner which results in the loan receivable being repaid faster than if the loan receivable were repaid by level debt service payments.

(2) The premium tax reduction determined as provided in Paragraph (1) of this Subsection shall be subject to the following limitations:

(a) For investments made during any taxable year beginning on or after January 1, 1989 and before January 1, 1990, the tax reduction shall not exceed forty percent of the tax liability for that taxable year.

(b) For investments made during any taxable year beginning on or after January 1, 1990 and before January 1, 1991, the tax reduction shall not exceed thirty percent of the tax liability for the respective taxable year.

(c) For investments made on or after January 1, 1991 and before January 1, 1999, the tax reduction utilized in any year for any group of affiliates shall not exceed twenty-five percent of the gross premium tax liability for such group, before any credits, for the year in which the investment was made.

(d) For investments made after December 31, 2003, no tax reduction shall be allowed.

(3) The tax reduction as determined by Paragraph (1) of this Subsection and as limited in Paragraph (2) of this Subsection shall be applied as follows: (a) for tax reduction credits granted to investors prior to January 1, 2001, the tax reduction shall be applied to the premium tax liability not to exceed ten percent of the premium tax reduction in any one year until one hundred percent of the premium tax reduction has been claimed by the insurer; or (b) for tax reduction credits granted to investors after January 1, 2001, the tax reduction shall not be applied to any premium tax liability generated within two years from the date of investment and shall be applied to the premium tax liability not to exceed twelve and one-half percent of the premium tax reduction in any one year until one hundred percent of the premium tax reduction has been claimed by the insurer; provided, the reduction in any taxable year shall not exceed the premium tax liability for such taxable year. Notwithstanding the provisions of this Paragraph to the contrary, if a holder of premium tax reduction credits authorized under this Subsection does not use credits that are generated after December 31, 1999, and which are eligible to be used in a given calendar year, those premium tax reduction credits may be carried forward and used in any subsequent year until such credits are exhausted; provided, the reduction in any taxable year shall not exceed the premium tax liability for such taxable year.

(4) The premium tax reductions described in Paragraphs (1), (2), and (3) of this Subsection shall have the same rights with respect to transferability accorded to income tax credits, as described in R.S. 51:1924(F) and be subject to the same forfeiture and repayment provisions as income tax credits, as described in R.S. 51:1927(C) and 1928(A).

Acts 1958, No. 125. Amended by Acts 1981, No. 662, §1; Acts 1984, No. 537, §1; Acts 1988, No. 130, §1; Acts 1989, 1st Ex. Sess., No. 15, §1, eff. March 17, 1989; Acts 1992, No. 849, §1; Acts 1993, No. 724, §1; Acts 1994, 3rd Ex. Sess., No. 9, §1; Acts 1996, No. 21, §1, eff. June 27, 1996; Acts 1998, No. 70, §1, eff. Oct. 1, 1998; Acts 2002, No. 84, §1, eff. June 25, 2002.

§1069. Exemption from franchise or capital stock tax

No insurer paying the license taxes levied under this Part shall be liable for any franchise or capital stock tax.

Acts 1958, No. 125.

§1070. Annual reports

Each insurer issuing such contracts, shall, on or before the first day of March of each year, render to the commissioner of insurance, a report signed by an officer of the insurer, or if an alien insurer, by its United States resident manager, or other officer in charge of its affairs in the United States, which shall certify to the amount of gross annual premiums on risks located in this state for the preceding year. The report shall also contain a statement of the portion of the total gross annual premiums reported which arose on risks actually located within the boundaries of any parish, city, town, or village in the state, which levies a license tax under the provisions of this Part. No credit shall be taken for reinsurance. The blanks for making such report shall be furnished by the commissioner of insurance.

Acts 1958, No. 125; Acts 2001, No. 183, §1, eff. Jan. 1, 2002.

§1071. Payment of tax

A. The license taxes levied under the provisions of this Part shall be paid to the commissioner of insurance at Baton Rouge and shall be remitted on a quarterly basis. The amount of the license taxes due on or before the fifteenth day of the month following the end of the quarter shall be equal to one-fourth of the total previous year's tax. At the end of the calendar year, the fourth quarter's report shall be adjusted to compensate for overpayments or underpayments of the tax based on that current year's gross receipts of taxable premiums and shall be due on or before March first of the following year and each year thereafter. Nothing herein contained shall be construed as relieving any insurer from paying to the commissioner of insurance the fees otherwise required or levied by law for qualifying to do business, or for the renewal thereof annually, or for agents' certificates of authority required by law. The legislative auditor may review any report submitted by an insurer for the payment of license taxes levied under the provisions of this Part.

B. Notwithstanding the provisions of Subsection A above, for the period July 1, 1984 through December 31, 1984 and the payment due on or before October 15, 1984, the amount of the license taxes due at the end of each quarter shall be equal to one-fourth of the total previous year's tax plus an amount equal to one-fourth of the additional amount which would have been due had the premiums collected during calendar year 1983 been taxed at the rates as provided in R.S. 22:1062 and 1065 as amended in 1984. Notwithstanding the provisions of Subsection A, for the period January 1, 1985 through December 31, 1985 and commencing with the payment due on or before April 15, 1985, the amount of license taxes due at the end of each quarter shall be equal to one-fourth of the amount which would have been payable for the previous year had the provisions of R.S. 22:1062 and 1065 as amended in 1984 been effective for the entirety of 1984. At the end of the 1984 calendar year, the report for the fourth quarter shall be adjusted to compensate for overpayments or underpayments of the tax based on the gross receipts of taxable premiums for 1984 and based upon rates as provided in R.S. 22:1062(B) and R.S. 22:1065(B).

Acts 1984, 1st Ex. Sess., No. 3, §1, eff. March 27, 1984; Acts 1991, No. 10, §1, eff. June 10, 1991.

§1072. Penalty on delinquent tax; revocation of authority to do business after thirty days' delinquency

A. In case of any failure to make a report or to make payment of license tax as required by this Chapter, a penalty of five percent if one to thirty days late, of ten percent if thirty-one to sixty days late, of fifteen percent if sixty-one to ninety days late, of twenty percent if ninety-one to one hundred twenty days late, or of twenty-five percent if more than one hundred twenty days late, shall be added to the amount of tax due and payable to the commissioner of insurance along with the tax due, unless evidence to his satisfaction is submitted to the commissioner to show that the failure was due to some unforeseen or unavoidable reason, other than mere neglect.

B. If the delinquency is for more than thirty days after the due date of the report or after the due date for payment of license taxes hereunder, neglect will be presumed and the penalty shall be added without any discretion on the part of the commissioner of insurance. After the lapse of thirty days, until the report is filed and the delinquent license paid, the commissioner of insurance shall revoke the authority of the delinquent taxpayer, and of all of said taxpayer's agents to do business in this state.

C. In no event shall the penalty exceed twenty-five percent of the total amount of the tax due nor be less than twenty-five dollars.

Acts 1958, No. 125. Acts 1984, No. 500, §1; Acts 1997, No. 523, §1; Acts 2001, No. 166, §1, eff. Jan. 1, 2002.

§1073. Investigation and enforcement by Commissioner of Insurance

The commissioner of insurance shall have authority to review and examine any sworn statements or accounts that may be rendered or furnished in pursuance of the provisions of this Part; and he shall have authority to demand and examine the books, statements, or accounts of any insurer from whom a license tax may be due and to take such proceedings before any court of competent jurisdiction by rule or otherwise, against any insurer from whom a license tax may be due as may be necessary to enforce a full and fair compliance with the provisions of this Part.

Acts 1958, No. 125.

§1074. Cost of collection and supervision

The commissioner of insurance is authorized to withhold from the funds collected under this Part, the sum of not to exceed ninety thousand dollars per annum to defray the expense of collecting taxes imposed by, and of enforcing this Part, and for the operation of the insurance department.

Acts 1958, No. 125.

§1075. Disposition of collections

Except as provided in R.S. 22:1074 and R.S. 22:1078, the commissioner of insurance shall keep complete books and records to show the amount of license taxes collected by him, and shall deposit all collections made by him under this Part in one of the fiscal agency banks having custody of other state funds, under a separate account to be kept under the title of "Insurance License Taxes."

Except as provided in R.S. 22:1074 and R.S. 22:1078, all license taxes imposed by this Part, when collected by the commissioner of insurance as herein provided, shall be paid by him into the state treasury not later than ten days after the end of the calendar month in which the collections are made. The annual collections not in excess of one million dollars shall be used exclusively for the maintenance, support, and improvement of Louisiana State University and Agricultural and Mechanical College; but if the collections in any one year exceed one million dollars, the excess shall be paid into the state general fund.

Acts 1958, No. 125.

§1076. Authorization of local license taxes; penalties for nonpayment

A. Any municipal or parochial corporation in the state shall have the right to impose a license tax on any insurer engaged in the business of issuing any form of insurance policy or contract, which may now or hereafter be subject to the payment of any license tax for state purposes, as provided in this Part, as follows:

(1) On any insurer engaged in the business of issuing life or accident or health insurance policies, other than programs of benefits authorized or provided pursuant to the provisions of Parts I and II of Chapter 12 of Title 42 of the Louisiana Revised Statutes of 1950, or other forms of contracts or obligations covering such risks, or issuing endowment or annuity policies, or contracts, or other similar forms of contract obligations in consideration of the payment of a premium or other consideration for the issuance of such policies, contracts, or obligations, whether such insurer is operating in this state through an agent or other representative or otherwise, not more than ten dollars on gross annual premiums up to two thousand dollars, and the additional license thereafter shall not be more than seventy dollars on each ten thousand dollars, or fraction thereof, of gross annual premiums in excess of two thousand dollars. Provided that the maximum license on such businesses, payable to such municipal or parochial corporation by any one insurer, shall not exceed twenty-one thousand dollars.

(2) On any insurer, engaged in the business of issuing policies, contracts, or other forms of obligations covering the risk of fire, marine, transportation, surety, fidelity, indemnity, guaranty, worker's compensation, employers' liability, property damage, live stock, vehicle, automatic sprinkler, burglary, or insurance business of any other kind whatsoever in this state, whether such insurer is operating in this state through agents or other representatives or otherwise, not more than the following:

(a) 1st Class: When the gross receipts are not more than two thousand dollars, the license shall not exceed forty dollars;

(b) 2nd Class: When the gross receipts are more than two thousand dollars, and not more than four thousand dollars, the license shall not exceed sixty dollars;

(c) 3rd Class: When the gross receipts are more than four thousand dollars, and not more than six thousand dollars, the license shall not exceed eighty dollars;

(d) 4th Class: When the gross receipts exceed six thousand dollars, the additional license thereafter shall not be more than seventy dollars for each ten thousand dollars, or fraction thereof, in excess of six thousand dollars.

B. The maximum license tax on such businesses, payable to such municipality or parochial corporation by any insurer, shall not exceed nine thousand dollars. Provided, that:

(1) Plate glass and steam boiler inspection insurers shall pay only one-third of the above rates provided in Paragraph A(2).

(2) The amount of license payable to any municipal or parochial corporation as fixed in this Section shall be one-third of the amount so fixed if the payer shall file a sworn statement with the annual report required by this Part, showing that at least one-sixth of the total admitted assets of the payer, are invested and maintained in qualifying Louisiana investments as defined in R.S. 22:1068(C).

(3) The total license tax payable by an insurer to a parish shall be calculated on the total direct premiums written by such insurer for risks located within unincorporated areas of such parish. The total license tax payable by an insurer to a municipality shall be calculated on the total direct premiums written by such insurer for risks located within such municipality. Such premiums shall not be subject to taxation by both the parish and the municipality. Such premiums shall not be subject to taxation by more than one parish or municipality.

C.(1) In case of any failure to make a report or to make payment of license tax as required by this Section, before June first of any year in which it is due, a penalty of five percent per month shall be added to the amount of tax due and payable to the municipal or parochial corporation along with the tax due. The municipal or parochial corporation may waive the payment of the penalty if it finds that failure to pay was due to some unforeseen or unavoidable reason, other than mere neglect.

(2) The amount of any monetary penalty assessed pursuant to this Section shall not be greater than twenty-five percent of the total amount of the tax due.

(3) When a payment is more than six months delinquent, the municipal or parochial corporation may send a written recommendation to the commissioner of insurance requesting the commissioner to revoke the authority of the delinquent taxpayer and all of the taxpayer's agents to do business in this state. Upon receiving such a recommendation and finding that the local tax assessment is correct and the insurer was duly notified of the assessment after the payment thereof is delinquent, the commissioner, after due notice to all affected parties and hearing, may revoke the authority of the taxpayer and all the taxpayer's agents to do business in this state.

Acts 1958, No. 125. Acts 1983, 1st Ex.Sess., No. 1, §6; Acts 1989, No. 405, §1; Acts 1990, No. 863, §1, eff. July 25, 1990; Acts 1992, No. 89, §1; Acts 2001, No. 799, §1, eff. June 26, 2001.

§1076.1. Local license taxes; contracts for collection; confidentiality of records

A. The taxes authorized by the provisions of R.S. 22:1076 and imposed by local ordinance may be collected by the Louisiana Municipal Advisory and Technical Services Bureau (LaMATS) if an agreement upon the terms of the collection procedure is executed between LaMATS and the municipality or parish imposing the taxes. Once such an agreement is executed, LaMATS is hereby endowed with all the rights, responsibilities, duties, and privileges of the municipality or parish in regard to the collection of the tax for the duration of the agreement.

B.(1) In accordance with the duty as collector, LaMATS shall have access to any information regarding local license taxes deemed necessary by the commissioner of insurance or the Department of Insurance if such access is necessary or proper for the enforcement of the laws of this state or of a political subdivision of this state.

(2) Except as otherwise provided by law, the records and files of LaMATS, as the contractually authorized collector of local license taxes, which are maintained pursuant to the local tax ordinances are confidential and privileged, and no person shall divulge or disclose any information obtained from such records and files except in the administration and enforcement of the tax laws of this state or of a political subdivision of this state.

(3) Neither the collector nor any employee engaged in the administration or charged with the custody of any such records or files shall be required to produce any of them for inspection or use in any action or proceeding, except in an action or proceeding in the administration or enforcement of the tax laws of this state or of a political subdivision.

(4) Nothing contained in this Section shall be construed to prevent such persons from disclosing a return of a taxpayer or the records or files maintained pursuant to the local tax ordinances by which LaMATS is contracted to collect as authorized by law in any judicial proceeding in which the state or any political subdivision thereof is a party.

Acts 2001, No. 799, §1, eff. June 26, 2001.

§1077. Fire marshal tax; Louisiana Fire Marshal Fund

A. There is hereby levied an additional tax of one and one-fourth percent of the gross annual premium receipts from any business which insures property of any nature or description against loss or damage by fire, less return premiums on all insurers doing business in the state which insure property of any nature or description against loss or damage by fire. This tax shall be paid by all such insurers to the commissioner of insurance when paying their annual license taxes under this Part, and the commissioner of insurance shall refuse to issue a license to any insurer failing or refusing to pay this additional tax.

B. All funds received by the commissioner of insurance pursuant to Subsection A hereof shall be deposited immediately upon receipt into the state treasury.

C. After compliance with the requirements of Article VII, Section 9(B) of the Constitution of Louisiana, relative to the Bond Security and Redemption Fund, and prior to monies being placed in the state general fund, an amount equal to that deposited as required by Subsection B hereof shall be credited to a special fund hereby created in the state treasury to be known as the "Louisiana Fire Marshal Fund". The monies in this fund shall be used solely as provided by Subsection D hereof and only in the amounts appropriated by the legislature. All unexpended and unencumbered monies in the fund at the end of the fiscal year shall revert to the state general fund. The monies in the fund shall be invested by the treasurer in the same manner as monies in the state general fund, and interest earned on the investment of these monies shall be credited to the state general fund, again, following compliance with the requirement of Article VII, Section 9(B) relative to the Bond Security and Redemption Fund.

D. The monies in the fund shall be used solely for the activities of the office of state fire marshal and only in the amount appropriated by the legislature. The fund shall be administered by the assistant secretary of the office of fire marshal of public safety services.

E. Except as otherwise specifically provided in R.S. 40:1563.5, there shall be no fees charged for inspections by the state fire marshal.

Acts 1958, No. 125; Amended by Acts 1958, No. 416, §1; Acts 1968, No. 446, §1; Acts 1972, No. 252, §1; Acts 1987, No. 738, §1; Acts 1991, No. 1056, §1; Acts 1993, No. 687, §1.

NOTE: See Acts 2003, No. 560, §§11 and 12 regarding balances in the fund for FY2002-2003.

§1078. Fees

The following fees and licenses shall be collected in advance:

A. By the secretary of state, the fee for filing the power of attorney.

B. By the commissioner of insurance:

(1) Certificates of authority, insurer, and rating

		organization, initial certificate	$2,500.00
(2)		For filing annual statement of insurer	$100.00
(3)		For producers' licenses:	
	(a)	Life, health, and accident producer; variable annuity producer	
		First time applicant	$75.00
		Additional or renewal company appointment (yearly)	$20.00
		Producer renewal fee (every 2 years)	$50.00
	(b)	Property and casualty producer:	
		First time applicant	$75.00
		Additional or renewal company appointment (yearly)	$20.00
		Producer renewal fee (every 2 years)	$50.00
	(c)	Limited lines producer	
		First time applicant	$75.00
		Each additional line of authority	$35.00
		Additional or renewal company appointment (yearly)	$20.00
		Renewal fee (every 2 years)	$50.00
	(d)	Limited lines credit insurance producer	
		First time applicant	$75.00
		Additional or renewal company appointment (yearly)	$20.00
		Renewal fee (every 2 years)	$50.00
	(e)	Surplus lines broker	
		First time applicant	$250.00
		Renewal fee (yearly)	$175.00
	(f)	Fee for failure to file producer license renewal timely (per license)	$50.00
	(g)	Fee for duplicate producer license	$15.00
(4)		For certified copies of any documents, per page	$3.00
(5)		Initial examination of insurance companies	$500.00
(6)		For Securities Fees	
		Registration of Securities-Minimum	$25.00
		Registration of Securities-Maximum (1/20 of 1% of the aggregate price)	$200.00
		Registration of Dealer	$50.00
		Registration of Salesman	$10.00
(7)		REPEALED BY ACTS 2001, No. 460, §2, eff. January 1, 2002.	
(8)		For filing a charter, other documents, and amendments thereto, per page	$2.00
(9)		For each company filing of self-insured health and accident insurance policy forms, per product	$100.00
(10)	(a)	For each company filing of property and casualty insurance policy forms, per product	$100.00
	(b)	For each company filing to adopt a reference or item filing of advisory organization's form reference filing (not applicable to service purchasers, who must file the actual forms as shown above)	$20.00
	(c)	For each company filing of property and casualty insurance policy endorsements, amendments, or riders	$25.00
(11)	(a)	For each company filing of life, health, and accident	

	insurance policy forms or health maintenance organization subscriber agreements, per product	$100.00
	(b) For each company filing of Medicare supplement insurance premium rates, rating schedule, and supporting documentation, per type of standard benefit plan	$100.00
	(c) For each company filing of Medicare supplement insurance advertisements, per submission	$100.00
(12)	For certification of a self-insured worker's compensation insurance program, an initial certification fee	$1,500.00
(13)	For review of a self-insured worker's compensation insurance program, an annual review fee	$300.00
(14)	Managing general agents	
	(a) Initial registration	$300.00
	(b) Annual registration	$300.00
	(c) Insurer's initial notice of appointment	$300.00
	(d) Insurer's annual notice of appointment	$300.00
(15)	Third party administrators	
	(a) Licensing fee	$500.00
	(b) Annual report filing fee	$300.00
(16)	Fee to accompany the statement required in anacquisition of control or merger with a domestic insurer	$2,500.00
(17)	Approval of foreign or alien surplus lines insurers	$1,050.00
(18)	(a) Registration of a risk purchasing group	$100.00
	(b) Annual renewal of registration for a risk purchasing group	$50.00
(19)	For viatical settlement licenses:	
	(a) Viatical settlement broker:	
	First time applicant	$50.00
	Annual renewal	$50.00
	(b) Viatical settlement investment agent:	
	First time applicant	$50.00
	Annual renewal	$50.00
	(c) Viatical settlement provider	
	First time applicant	$1,000.00
(20)	For filing viatical settlement contracts, disclosure notices, and advertising materials, per filing:	$100.00
(21)	For the initial registration of a risk retention group	$1, 000.00

C. The commissioner of insurance is authorized to withhold the funds collected under Paragraph (6) of Subsection 3 of this Section.

D. The commissioner of insurance is authorized to withhold the funds collected under Paragraphs (1) and (2) of Subsection (B) of this Section to defray the cost of printing and mailing of the annual reports and premium tax forms as required by R.S. 22:1451 and R.S. 22:1070 subject to all annual budgetary requirements of the state of Louisiana.

E. The fees stated herein shall supersede any statement of fees in any individual section of the Code.

F. However, any Louisiana domestic insurer owned exclusively by Louisiana residents or by a corporation that is owned exclusively by Louisiana residents shall be exempt from paying fees provided for under Subparagraphs B(3)(a) and (b)(i) of this Section, only as it relates to additional or renewal company appointment (yearly). Each insurer applying for exemption of fees, under this Section, shall file with the Louisiana Department of Insurance a notarized affidavit certifying the ownership of the insurer as being owned exclusively by Louisiana residents or by a corporation that is owned exclusively by Louisiana residents.

G. The commissioner may, after notice and hearing, promulgate such rules and regulations as may be necessary and proper to carry out the provisions of this Section. Such rules and regulations shall be promulgated and adopted in accordance with the Administrative Procedure Act.

Acts 1958, No. 125. Amended by Acts 1960, No. 391, §1; Acts 1970, No. 106, §1; Acts 1981, No. 663, §1; Acts 1983, 1st Ex. Sess., No. 25, §1, eff. Mar. 1, 1983; Acts 1983, 1st Ex. Sess., No. 18, §1, eff. Mar. 18, 1983; Acts 1992, No. 381, §1; Acts 1992, No. 1135, §1; Acts 1993, No. 295,

§1; Acts 1999, No. 342, §6; Acts 1999, Nos. 299, 912, §§1; Acts 2001, No. 460; §§1 & 2, eff. January 1, 2002; Acts 2002, 1st Ex. Sess., No. 87, §1, eff. June 16, 2002; Acts 2003, No. 343, §1; Acts 2004, No. 376, §1.

§1079. Retaliatory taxes and fees

When, by the laws of any other state, any taxes, fines, penalties, licenses, deposits, or other obligations or prohibitions, additional to or in excess of those imposed by the laws of this state upon insurers organized under the laws of other states, are imposed or would be imposed on insurers of this state, the same taxes, fines, penalties, licenses, deposits, and other obligations or prohibitions shall be imposed upon all insurers of such state as long as such laws remain in force. Every insurer organized under the laws of any other state and admitted to transact business in this state shall pay the same fees to the commissioner of insurance of this state as such other state may require of any similar insurer incorporated by or organized under the laws of this state. Alien insurers shall pay the same fees as are imposed in the state where the deposit is made under of R.S. 22:983(C). Assessments by insurance guaranty associations or similar organizations are not considered in determining retaliatory taxation.

Acts 1978, No. 125. Amended by Acts 1970, No. 84, §1; Acts 2001, No. 460, §1, eff. Jan. 1, 2002.

§1080. Assessment on insurance premiums; method of collection; disbursement

A. In addition to all other taxes and assessments, each insurer other than a life insurer shall be assessed and within sixty days after December 31 of each year shall pay to the commissioner of insurance a sum equal to one-fourth of one percent of the amount of premiums received in this state by such insurer during the preceding year ending December 31. Such assessment shall be imposed on all insurance premiums received for the insurance against loss or damage by fire of property of whatever nature and kind in the state of Louisiana.

B. Each insurer shall submit to the commissioner of insurance a just and true account, as verified by one of its officers or other person having authority to verify such accounts of the total insurance premiums received by such insurer for insurance premiums for insurance of property of whatever nature and kind from loss or damage by fire in the state of Louisiana during the year ending December 31 of each year.

C. The state treasurer shall credit the proceeds from such assessment to a special account established in the state treasury from which disbursement shall be made by the state treasurer of all the funds collected from such assessment to the Louisiana State University and Agricultural and Mechanical College, Division of Continuing Education, to be used solely for the expenses in connection with the in-service fireman training program and the necessary facilities in connection therewith.

Added by Acts 1970, No. 32, §1; Acts 1984, No. 229, §1; Acts 1991, No. 1014, §1, eff. July 1, 1991.

§1081. Collection of delinquent taxes and fees; additional amounts to be collected

The commissioner is authorized to collect any delinquent taxes and fees under this Part, or to represent the department in any proceeding under this Part. If any delinquent taxes or fees due under this Part require institution of legal proceedings to collect such tax or fee, a penalty in an amount not to exceed twenty percent of the delinquent fee or tax shall be paid by the delinquent person to cover the cost of investigation, administration, and collection. At the sole discretion of the commissioner of insurance, the commissioner may refer the collection of delinquent taxes and fees to the attorney general for collection by the staff of the attorney general. If the collection is referred to the attorney general for collection by the staff of the attorney general, the additional penalty provided for in this Section is to be divided equally between the Department of Insurance and the Department of Justice.

Acts 1992, No. 703, §1.

PART XXIV. QUALIFICATION AND LICENSE REQUIREMENTS FOR INSURANCE AGENTS, BROKERS, SURPLUS LINES BROKERS, AND SOLICITORS

§1111. REPEALED BY ACTS 2001, No. 158, §2, eff. Jan. 1, 2002.
§1112. REPEALED BY ACTS 2001, No. 158, §2, eff. Jan. 1, 2002.
§1113. REPEALED BY ACTS 2001, No. 158, §2, eff. Jan. 1, 2002.
§1114. REPEALED BY ACTS 2001, No. 158, §2, eff. Jan. 1, 2002.
§1115. REPEALED BY ACTS 2001, No. 158, §2, eff. Jan. 1, 2002.
§1116. REPEALED BY ACTS 2001, No. 158, §2, eff. Jan. 1, 2002.
§1117. REPEALED BY ACTS 2001, No. 158, §2, eff. Jan. 1, 2002.
§1118. REPEALED BY ACTS 2001, No. 158, §2, eff. Jan. 1, 2002.
§1118.1. REPEALED BY ACTS 1999, No. 882, §2, eff. July 2, 1999.
§1118.2. REPEALED BY ACTS 1999, No. 882, §2, eff. July 2, 1999.
§1119. REPEALED BY ACTS 2001, No. 158, §2, eff. Jan. 1, 2002.
§1120. REPEALED BY ACTS 1993, NO. 952, §2, EFF. JAN. 1, 1994.
§1121. REPEALED BY ACTS 1993, NO. 952, §2, EFF. JAN. 1, 1994.
§1122. REPEALED BY ACTS 1993, NO. 952, §2, EFF. JAN. 1, 1994.
§1123. REPEALED BY ACTS 1993, NO. 952, §2, EFF. JAN. 1, 1994.
§1124. REPEALED BY ACTS 1993, NO. 952, §2, EFF. JAN. 1, 1994.

PART XXV. QUALIFICATION AND LICENSE REQUIREMENTS FOR INSURANCE PRODUCERS

§1131. Purpose and scope

This Part shall govern the qualifications and procedures for the licensing of insurance producers. These provisions shall apply to any and all lines of insurance and types of insurers, including but not limited to life, health, property, liability, credit, title, fire, or marine, operating on a stock, mutual reciprocal, fraternal benefit, hospital, or medical service plan, as set forth in this Part.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

§1132. Definitions

As used in this Part, unless the context requires otherwise, the following definitions shall be applicable:

(1) "Authorized insurer" shall mean any type of insurer other than surplus lines or unauthorized insurer.

(2) "Business entity" shall mean a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

(3) "Commission" shall mean a fee paid to an insurance producer as a percentage of the premium generated by a sold insurance policy, or direct compensation or reward of a producer when the same is calculated as a flat fee or as a percentage of the premium or on the profit to the principal.

(4) "Home state" shall mean the District of Columbia or any state or territory of the United States in which an insurance producer maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer.

(5) "Insurance" shall mean any of the lines of authority as specified in R.S. 22:1137.

(6) "Insurance producer" shall mean a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance, and includes all persons or business entities otherwise referred to in the Louisiana Insurance Code as "insurance agent" or "agent", or "insurance broker" or "broker", or "insurance solicitor" or "solicitor", or "surplus lines broker".

(7) "Insurer" shall have the same definition as set forth in R.S. 22:5.

(8) "License" shall mean a document issued by this state's commissioner of insurance authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent, or inherent, in the holder to represent or commit an insurance carrier.

(9) "Limited line credit insurance" includes credit life, as defined in R.S. 22:6(16) and R.S. 6:969.6(12), credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation that the commissioner of insurance determines should be designated a form of limited line credit insurance.

(10) "Limited line credit insurance producer" shall mean an insurance producer who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy.

(11) "Limited lines insurance" is any authority granted by the commissioner of insurance which restricts the authority of the licensee to less than the total authority prescribed in the associated major lines pursuant to R.S. 22:1137(A)(1) through (5).

(12) "Limited lines producer" shall mean an insurance producer authorized by the commissioner of insurance to sell, solicit, or negotiate limited lines insurance.

(13) "NAIC" shall mean the National Association of Insurance Commissioners or its successor.

(14) "Negotiate" shall mean to confer directly with or to offer advice directly to a purchaser, certificate holder, or enrollee, or prospective purchaser, certificate holder, or enrollee, of a particular contract of insurance, including certificates, riders, endorsements, or amendments, concerning any of the benefits, terms, or conditions of the contract, provided that the person engaged in that act is an insurance producer who either sells insurance or obtains insurance from insurers for purchasers, certificate holders, or enrollees.

(15) "Person" shall mean any natural or artificial legal entity including but not limited to individuals, partnerships, associations, trusts, or corporations.

(16) "Sell" shall mean to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurer.

(17) "Solicit" shall mean to attempt to sell insurance or to ask or urge a person to apply for a particular kind of insurance from a particular insurer.

(18) "Surplus lines broker" shall mean an insurance producer who solicits, negotiates, or procures a property and casualty policy with an insurance company not licensed to transact business in the state which cannot be procured from insurers licensed to do business in this state. All transactions entered into under such license shall be subject to R.S. 22:1249 et seq.

(19) "Terminate" shall mean to cancel the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance.

(20) "Uniform application" shall mean the current version of the NAIC Uniform Application for resident and nonresident producer licensing.

(21) "Uniform Business Entity Application" shall mean the current version of the NAIC Uniform Business Entity Application for resident and nonresident business entities.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

§1133. License required

A. No person shall act as or hold himself out to be an insurance producer unless licensed by the Department of Insurance.

B. No insurance producer shall sell, solicit, make an application for, procure, negotiate for, or place for others, any policies for any lines of insurance as to which he is not then qualified and duly licensed in this state.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

§1134. Exceptions to licensing; prohibitions

A. Nothing in this Part shall be construed to require an insurer to obtain an insurance producer license. In this Section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries, or affiliates.

B. A license as an insurance producer shall not be required of the following:

(1) An officer, director, or employee of an insurer or of an insurance producer, provided that the officer, director, or employee does not receive any commission on policies written or sold to insure risks residing, located, or to be performed in this state and:

(a) The officer's, director's, or employee's activities are executive, administrative, managerial, clerical, or a combination of these, and are not the sale, solicitation, or negotiation of insurance;

(b) The officer's, director's, or employee's function relates to underwriting, loss control, inspection, or the processing, adjusting, investigating, or settling of a claim on a contract of insurance; or

(c) The officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation, or negotiation of insurance.

(2) A person who secures and furnishes information for the purpose of group life insurance, group annuities, group or blanket accident and health insurance; or for the purpose of enrolling individuals under plans, issuing certificates under plans, or otherwise assisting in administering plans; or performs administrative services related to mass marketed property and casualty insurance; where no commission is paid to the person for the service.

(3) An employer or association or its officers, directors, employees, or the trustees of an employee trust plan, to the extent that the employer's or association's officers, employees, director, or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, as long as the employer, association, officers, directors, employees, or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts.

(4) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating, or classification of risks, or in the supervision of the training of insurance producers and who are not individually engaged in the sale, solicitation, or negotiation of insurance.

(5) A person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of this state, provided that the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in this state.

(6) A person who is not a resident of this state who sells, solicits, or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract, provided that person is otherwise licensed as an insurance producer to sell, solicit, or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state.

(7) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer provided that the employee does not sell or solicit insurance or receive a commission.

(8) Employees of an insurer or of an insurance producer who respond to requests from existing policyholders, on existing policies, provided that those employees are not directly compensated based on the volume of premiums that may result from these services and provided those employees do not sell, solicit, or negotiate insurance.

C.(1) The Department of Insurance shall not grant, renew, reinstate, or permit to continue any license if the license is being or will be used by the applicant or licensee for the sole purpose of writing controlled business. For purposes of this Part, "controlled business" shall mean either of the following:

(a) Insurance written on the interests of the licensee or those of his immediate family or of his employer.

(b) Insurance covering himself or members of his immediate family, or a corporation, association, or partnership, or the officers, directors, substantial stockholders, partners, or employees of a corporation, association, or partnership, of which he or a member of his immediate family is an officer, director, substantial stockholder, partner, associate, or employee.

(2) Nothing in this Subsection shall apply to insurance written in connection with any credit transactions.

(3) Any license under this Subsection shall be deemed to have been, or intended to be, used for the purpose of writing controlled business, if the Department of Insurance determines that during any twelve-month period the aggregate commissions earned from the controlled business has exceeded twenty-five percent of the aggregate commissions earned on all business written by such applicant or licensee during the same period.

D. No person shall be licensed as an insurance producer, limited lines producer, surplus lines broker, or managing general agent in this state if they, or any person who owns directly or indirectly more than ten percent of the beneficial interest in a business entity applying for a license, are either a citizen of, resident of, domiciled in, or the commissioner determines that they or the beneficial owner maintain significant assets in, a country that the commissioner determines does not give full faith and credit to any judgment rendered by a court of this state or of the United States, or that the country does not have laws similar to those of this state for the discovery of assets of the insurer, seizure or sale of such assets, and execution of a judgment thereof.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

§1135. Examination

A. A resident individual applying for an insurance producer license shall pass an examination unless exempt pursuant to R.S. 22:1139. The examination shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer, and the insurance laws and regulations of this state. Examinations required by this Section shall be developed and conducted under rules and regulations prescribed by the commissioner of insurance.

B.(1) After completion and filing of an application with the commissioner of insurance, the commissioner shall subject each applicant for a license as an insurance producer or limited lines producer to an examination.

(2) If the applicant is a partnership, corporation, or other business entity, the examination shall be taken by each individual who is to be named in or registered on the license for the partnership, corporation, or other business entity and who is engaged in the sale, solicitation, or negotiation of insurance.

(3) All the lines of insurance which the applicant proposes to transact under the license applied for shall require an examination to be taken.

(4) The applicant shall pass the examination with a score at or above the seventieth percentile to indicate a satisfactory knowledge and understanding of lines of insurance for which the applicant seeks qualification.

C. Any person applying for a license as an insurance producer, prior to taking the examination required by this Part, shall file with the Department of Insurance, in a manner prescribed by the commissioner, certification that the applicant has completed a registered prelicensing program certified by the commissioner pursuant to R.S. 22:1191. This Subsection shall not apply to any applicant seeking authorization to write industrial fire, fidelity and surety, vehicle physical damage, title, surplus lines, credit life, credit accident and health, credit property and casualty, or variable annuity insurance business only.

D. All examinations shall be conducted frequently and at a place or places reasonably accessible to all applicants. The commissioner of insurance may promulgate reasonable rules and regulations providing the procedure for the examinations.

E. The content of the examination may be outlined in the licensing information handbook provided to applicants by the Department of Insurance, publishers of examination study materials, any prelicensing providers, and others wishing to provide this information.

F. The commissioner of insurance may appoint an advisory committee for recommendations as to the scope, type, and quality of examinations, as well as the content of study materials, as provided in R.S. 22:1192.

G. The commissioner may contract, in accordance with R.S. 39:1551 et seq., with one or more private testing services for administering examinations and collecting examination fees. The commissioner may require that the applicant pay the cost of the examination directly to the testing firm.

H. A person who fails to appear for the examination as scheduled, or fails to pass the examination, must reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

§1136. Application for license

A. A person applying for a resident insurance producer license shall make application to the commissioner of insurance on the Uniform Application and declare under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the commissioner shall find that the individual:

(1) Is at least eighteen years of age.

(2) Resides in the state or maintains his principal place of business in the state.

(3) Is not disqualified for having committed any act that is a ground for denial, suspension, or revocation set forth in R.S. 22:1142.

(4) Has completed a prelicensing course of study for the lines of authority for which the person has applied.

(5) Has paid the fees set forth in R.S. 22:1078.

(6) Has successfully passed the examinations for the lines of authority for which the person has applied.

(7) When applicable, has the written consent of the commissioner of insurance pursuant to 18 U.S.C. 1033, or any successor statute regulating crimes by or affecting persons engaged in the business of insurance whose activities affect interstate commerce.

B.(1)(a) A business entity acting as an insurance producer is required to obtain an insurance producer license. Every member, partner, officer, director, stockholder, and employee of the business entity personally engaged in this state in soliciting or negotiating policies of insurance shall be registered with the Department of Insurance under such business entity's license, and each such member, partner, officer, director, stockholder, or employee shall also qualify as an individual licensee for any line of insurance the business entity is licensed to transact. Licensing of any limited liability company or limited liability partnership as an insurance producer is subject to prior approval of the commissioner of insurance.

(b) The business entity licensee shall within thirty days notify the commissioner of insurance of any change of status of an individual who is registered under the business entity license.

(c) Any business entity operating at more than one location shall notify the commissioner of insurance of each permanent branch location address within thirty days from the date of the opening of the new location. There must be at least one individual licensed insurance producer registered with the Department of Insurance for each branch location.

(d) Any business entity which fails to comply with this Subsection shall be subjected to a fine of one hundred dollars for each violation. Any entity against which a fine has been levied shall be given due notice of such action. Upon receipt of this notice, the entity may apply for and shall be entitled to a hearing.

(2) Application shall be made using the Uniform Business Entity Application. Before approving the application, the commissioner of insurance shall find that:

(a) The business entity has paid the fees set forth in R.S. 22:1078.

(b) The business entity has designated one or more licensed individual producers responsible for the business entity's compliance with the insurance laws, rules, and regulations of this state.

(3) The Uniform Business Entity Application shall be accompanied by:

(a) If a corporation or a limited liability company, a current letter of good standing from the secretary of state's office, verification by the secretary of the corporation that the directors and officers were duly appointed or elected in accordance with the articles of incorporation and bylaws of the corporation, and an attestation by the president of the corporation disclosing the identity and percentage of ownership of all officers and directors, and of those persons who own ten percent or more of the owner applicant as that term is used in the Uniform Business Entity Application.

(b) If a partnership or a limited liability partnership, a current letter of registration from the secretary of state's office, verification by the appropriate partner that the partners listed on the application are duly named as partners in accordance with the partnership agreement, and a statement under oath verifying the percentage of interest and control of each partner in the partnership.

(c) If a bank chartered under the laws of this or any state, or of the United States, a current letter of good standing from its chartering authority, verification by the cashier or secretary of the bank that the directors and executive officers were duly appointed or elected in accordance with the articles and bylaws of the bank, and an attestation by the president of the bank disclosing the identity and percentage of ownership of the shareholders who own ten percent or more of the bank; such shareholders owning ten percent or more of the shares of the bank shall constitute the owners, and such executive officers shall constitute the officers, as those terms are used in the Uniform Business Entity Application.

(d) If an association or other business entity, such documentation as the commissioner of insurance may deem necessary and appropriate.

(4) When completing the background information portion of the Uniform Business Entity Application pertaining to the disclosure of certain lawsuits or arbitration proceedings, corporations, banks, partnerships, or other business entities, and their executive officers and directors, shall disclose those proceedings occurring within the past five years which are considered to be material under generally accepted accounting principles for purposes of financial statement disclosure.

C. Any professional law corporation formed pursuant to R.S. 12:801 et seq., or any limited liability company, limited liability partnership, or partnership formed for the practice of law, as authorized by R.S. 37:213, may be licensed as a title insurance producer.

D. The commissioner of insurance may require any documents deemed necessary to verify the information contained in an application.

E. Each insurer that sells, solicits, or negotiates any form of limited line credit insurance shall provide to each individual whose duties will include selling, soliciting, or negotiating limited line credit insurance a program of instruction that may be approved by the commissioner of insurance.

F. Any license issued pursuant to an application claiming residency for licensing purposes, as defined herein, shall constitute an election of residency in the state, and shall be void if the licensee while maintaining a resident license also maintains a license in, or thereafter submits an application for a license in, any other state or other jurisdiction stating that the applicant is a resident of such other state or jurisdiction, or if the licensee ceases to be a resident of this state.

G. Except as authorized by R.S. 6:242, no bank, bank holding company, or any subsidiary or employee thereof shall be licensed as or engage in any insurance activity as an insurance producer. However, a bank which was engaged as an insurance producer on January 1, 1984, may continue to be so engaged. The commissioner shall license any qualified state or national bank, bank holding company, or any subsidiary or employee thereof to engage in any insurance or annuity activity as authorized by R.S. 6:242, as an insurance producer.

H. In addition to the authority conferred by Subsection G of this Section, or R.S. 6:242, a bank, bank holding company, or any subsidiary or employee thereof shall have and possess, and may exercise, such rights, powers, privileges, and immunities of a national bank or national bank branch engaged in insurance sales activities in this state.

Added by Acts 2001, No. 158, §1, eff. January 1, 2002; Acts 2005, No. 228, §1, eff. June 29, 2005.

§1137. License

A. Unless denied licensure pursuant to R.S. 22:1142, persons who have met the requirements of this Part shall be issued an insurance producer license. An insurance producer may receive qualification for a license in one or more of the following lines of authority:

(1) Life, which provides insurance coverage on human lives, and may include benefits in the event of death or dismemberment by accident and benefits for disability income.

(2) Health and accident, which provides insurance coverage for sickness, bodily injury, or accidental death, and may include benefits for disability income.

(3) Annuities, which includes variable life and variable annuity products.

(4) Property, which provides insurance coverage for the direct or consequential loss or damage to property of every kind. A license for property insurance shall be for either personal lines, defined as property insurance coverage sold to individuals and families for primarily noncommercial purposes, or commercial lines, defined as anything other than personal lines, or both.

(5) Casualty, which provides insurance coverage against legal liability, including that for death, injury or disability, or damage to real or personal property. A license for casualty insurance shall be for either personal lines, defined as casualty insurance coverage sold to individuals and families for primarily noncommercial purposes, or commercial lines, defined as anything other than personal lines, or both.

(6) Title.

(7) Credit life.

(8) Credit health and accident.

(9) Credit property and casualty.

(10) Automobile club service contract and membership.

(11) Travel.

(12) Baggage.

(13) Industrial life.

(14) Industrial health and accident.

(15) Industrial fire.

(16) Fidelity and surety.

(17) Vehicle physical damage.

(18) Health maintenance organization subscriber agreements.

(19) Bail bonds.

(20) Home service life.

(21) Surplus lines, subject to the requirements of Subsection I of this Section.

(22) Any other line of insurance permitted under state laws or regulations.

B. Subject to the requirements of Subsection C of this Section, an insurance producer license shall remain in effect, unless revoked, suspended, or denied renewal or reinstatement, as long as all applicable fees are paid and education requirements are satisfied, until the license expires or is surrendered by the holder thereof.

C.(1) Every licensed producer shall file an application for renewal of his license every two years, by notifying the commissioner of insurance, by methods prescribed by the commissioner, of the licensee's intention to continue his license as either producer, limited lines producer, or surplus lines producer.

(2) Any licensee who fails to file timely for license renewal shall be charged a late fee of twenty-five dollars, or other such amount as may be authorized by R.S. 22:1078, for each license not renewed timely.

(3) Prior to the filing date for application for renewal of a license, the licensee shall comply with continuing education requirements in R.S. 22:1193 for the lines of insurance being renewed. Such producer shall file with the commissioner of insurance, by a method prescribed by the commissioner, satisfactory certification of completion of the continuing education requirements. Any failure to fulfill the continuing education requirements shall result in the expiration of the license. Nothing in this Subsection shall authorize the administration or management, under contract or otherwise, of the continuing education program except by the employees of the department.

D. An insurance producer who allows his or her license to lapse may, within five years from the expiration date of the license, reinstate the same license upon proof of fulfilling all continuing education requirements through the date of reinstatement and upon payment of all fees due. If the license has been lapsed for more than five years, the applicant shall fulfill the requirements for issuance of a new license.

E. A licensed insurance producer who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance, such as a long-term medical disability, may request a waiver of those procedures. The producer may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.

F. The license shall state the name and mailing address of the licensee, date of issuance, the renewal or expiration date, the line or lines of insurance covered by the license, and such other information as the commissioner of insurance deems necessary.

G. Every licensee shall notify the commissioner, by any means acceptable to the commissioner, of any alteration in his residential, mailing, or business address within ten days of the alteration. Failure to file an address change within the required time shall result in the imposition of a fifty-dollar penalty per violation, or as may be authorized by R.S. 22:1078. Any person against whom a penalty has been levied shall be given due notice of such action. Upon receipt of this notice, the licensee may apply for and shall be entitled to a hearing.

H. A duplicate license may be issued for any lost, stolen, or destroyed license issued pursuant to this Part upon a request by the licensee, by a method prescribed by the commissioner, setting forth the facts of such loss, theft, or destruction, together with a fee of five dollars, or such amount as may be authorized by R.S. 22:1078.

I. Any licensed insurance producer maintaining an office at a designated location in this state and having at least two years experience in the insurance business with an insurer or as an insurance producer may be licensed as a surplus lines broker as follows:

(1) The applicant must submit an application to the commissioner of insurance for the license on forms approved by the commissioner.

(2) The applicant must submit the required license fee, as authorized by R.S. 22:1078, for each license year during any part of which the license is in effect. The license shall remain in force until the annual renewal date.

(3) Passage of an examination approved by the commissioner of insurance.

J. In order to assist in the performance of the commissioner's duties, the commissioner may contract with nongovernmental entities, including the National Association of Insurance Commissioners (NAIC) or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions, including the collection of fees, related to producer licensing that the commissioner and the nongovernmental entity may deem appropriate.

K. The commissioner may participate, in whole or in part, with the National Association of Insurance Commissioners (NAIC), or any affiliates or subsidiaries the NAIC oversees, in a centralized producer license registry where insurance producer licenses and appointments may be centrally or simultaneously effected for all states that require an insurance producer license and participate in such centralized producer license registry. If the commissioner finds that participation in such a centralized registry is in the public interest, the commissioner may adopt by rule any uniform standards and procedures as are necessary to participate in the registry. Any participation in a centralized registry shall be under the administration and control of employees of the department and may not be the subject of any contract for services with any person or entity outside of the department.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

§1138. Nonresident licensing

A. Unless denied licensure pursuant to R.S. 22:1142, a nonresident person shall receive a nonresident producer license if:

(1) The person is currently licensed as a resident and in good standing in his or her home state.

(2) The person has submitted the proper request for licensure and has paid the fees required by R.S. 22:1078.

(3) The person has submitted or transmitted to the commissioner of insurance the application for licensure that the person submitted to his or her home state, or in lieu of the same, a completed Uniform Application.

(4) The person's home state awards nonresident producer licenses to residents of this state on the same basis.

B.(1) The commissioner of insurance may verify the producer's licensing status through the producer database maintained by the National Association of Insurance Commissioners, its affiliates, or subsidiaries.

(2) Whenever, by the laws or regulations of any other state or jurisdiction, any limitation of rights and privileges, conditions precedent, or any other requirements are imposed upon residents of this state who are nonresident applicants or licensees of such other state or jurisdiction in addition to, or in excess of, those imposed on nonresidents under this Part, the same such requirements shall be imposed upon such residents of such other state or jurisdiction.

(3)(a) The commissioner of insurance shall not issue a license to any nonresident applicant until such applicant has filed forms approved by the commissioner which designate the commissioner as his true and lawful agent, upon whom may be served all lawful process in any action, suit, or proceeding instituted by or on behalf of any interested person arising out of the applicant's insurance business in this state. The designation shall constitute an agreement that such service of process has the same legal force and validity as personal service of process upon the person in the state.

(b) The service of process upon any such licensee in any action or proceeding in any court of competent jurisdiction may be made by a party serving the commissioner of insurance with appropriate copies thereof and the payment to him of a fee of twenty-five dollars, or as may be authorized by R.S. 22:1078.

(c) The commissioner of insurance shall, within ten days of being served, forward a copy of such process by registered or certified mail, return receipt requested, to the licensee at his last known address of record or principal place of business, and the commissioner shall maintain copies of all such processes so served upon him.

(4) The service of process upon any such licensee in any action or proceeding instituted by the commissioner of insurance under this Part shall be made by the commissioner by mailing such process by registered or certified mail, return receipt requested, to the licensee at his last known address of record or principal place of business.

C. A nonresident producer who moves from one state to another state or a resident producer who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty days of the change of legal residence. No fee or license application is required.

D.(1) Notwithstanding any other provision of this Part, an insurance producer licensed as a surplus lines broker in his home state shall receive a nonresident surplus lines broker license pursuant to Subsection A of this Section.

(2) Except as provided by Subsection A of this Section, nothing in this Section otherwise amends or supersedes any provision of R.S. 22:1249 et seq.

E. Notwithstanding any other provision of this Part, a person licensed as a limited line credit insurance or other type of limited lines producer in his home state shall receive a nonresident limited lines producer license, pursuant to Subsection A of this Section, granting the same scope of authority as granted under the license issued by the producer's home state. For the purposes of this Subsection, limited line insurance is any authority granted by the home state which restricts the authority of the licensee to less than the total authority prescribed in the associated major lines pursuant to R.S. 22:1137(A)(1) through (5).

Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

§1138.1. Specialty limited lines credit insurance

A.(1) A licensed insurance producer or limited line credit insurance producer may be issued a specialty limited lines credit insurance producer license pursuant to the provisions of this Section.

(2) No producer shall sell, solicit, or negotiate credit life, credit health and accident, or credit property and casualty insurance pursuant to a specialty limited lines credit insurance producer license other than (i) in connection with retail sales transactions not exceeding ten thousand dollars per retail sales transaction; (ii) in connection with retail sales of motor vehicles wherein the transaction exceeds ten thousand dollars as provided in rules and regulations promulgated by the commissioner of insurance; or (iii) as provided by rules and regulations adopted by the commis sioner of insurance.

(3) All insurance written pursuant to a specialty limited lines credit insurance producer license shall be insured by a domestic insurer or foreign or alien insurer admitted in this state.

B. For a specialty limited lines credit insurance producer license to be issued pursuant to this Section, an applicant must submit to the commissioner all of the following:

(1) An application, submitted in a manner prescribed by the commissioner of insurance, containing such information as prescribed by the commissioner, including verification that the applicant is currently licensed as an insurance producer or limited line credit insurance producer.

(2) A list of the physical locations where activities authorized by the specialty limited lines credit insurance producer license will be conducted.

(3) A list of the employees or representatives of the applicant, as of the date of application, to be registered pursuant to this Section.

(4) An application fee in the amount of one thousand dollars, or for an applicant registering twenty or fewer employees or representatives, an application fee in the amount of two hundred fifty dollars, or such other amount as may be authorized by R.S. 22§1078.

(5) Upon approval of the application, but prior to issuance of the license, the applicant shall submit a registration fee of twenty dollars per employee or representative to be registered by the licensee; however, the registration fee shall not exceed two thousand five hundred dollars annually for each licensee.

C. Following initial issuance of the specialty limited lines credit insurance producer license, the licensee shall submit an annual renewal application, in a manner prescribed by the commissioner, along with an annual renewal fee of five hundred dollars, or for a licensee registering twenty or fewer employees or representatives, an annual renewal fee of one hundred twenty-five dollars, and an annual renewal registration fee of ten dollars per employee or representative of the licensee, or such other amounts as may be authorized by R.S. 22:1078.

D. The licensee shall submit, in a manner prescribed by the commissioner, a current list of employees and representatives for verification by the commissioner every six months, in addition to an initial registration fee of twenty dollars per employee or representative not previously registered.

E. A specialty limited lines credit insurance producer license issued pursuant to this Section authorizes an employee or representative of the license holder to participate in enrollment of retail sales and credit customers in the types of insurance specified in this Section without being licensed, provided all of the following is true:

(1) The employee or representative operates with permission from and under the supervision of the license holder.

(2) The employee or representative has been instructed with respect to the disclosures which may be required to be made to consumers in connection with the sale of credit insurance.

(3) The employee or representative is not primarily compensated based on the amount of insurance for which the employee or representative enrolls customers.

F. A specialty limited lines credit insurance producer may not in any manner advertise, represent, or otherwise hold out any employee or representative of the license holder as a licensed insurance agent pursuant to another provision of this Part, unless the entity or individual actually holds the applicable license.

G. If a specialty limited lines credit insurance producer violates any provision of this Part, the commissioner of insurance may, after notice and opportunity for a hearing, impose any penalties he deems necessary or appropriate to enforce the provisions of this Part, including but not limited to placing the license holder on probation, suspending, revoking, or refusing to renew or reinstate the license, assessing an administrative penalty against the license holder, suspending the transaction of insurance business at specific locations where a violation of this Part has occurred, or any combination of penalties authorized by this Part.

H. The specialty limited lines credit insurance producer license shall be available equally to residents and nonresidents, provided that if the laws or regulations of any other state would not permit a specialty limited lines credit insurance producer that is a resident of this state to obtain a substantially equivalent nonresident license, then residents of that state shall not be permitted to obtain a specialty limited lines credit insurance producer license as nonresidents under this Section.

I. Notwithstanding any other provision of this Title, this Section specifically permits the sale of both group and individual credit insurance, in both single and joint coverages. A licensee under this Section may receive commissions or other compensation for services rendered in connection with the sale of credit insurance pursuant to this Section.

J. The commissioner of insurance may, in accordance with state law, adopt reasonable regulations as are necessary or proper to carry out the purposes of this Part.

Acts 2001, No. 170, §1; Acts 2003, No. 933, §1; Acts 2003, No. 1224, §1.

§1139. Exemption from examination

A. An individual who applies for an insurance producer license in this state who was previously licensed for the same lines of authority in another state shall not be required to complete any prelicensing education or examination. This exemption is available only if the person is currently licensed in that state or if the application is received within ninety days of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's Producer Database records, maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries, indicate that the producer is or was licensed in good standing for the line of authority requested.

B. A person licensed as an insurance producer in another state who moves to this state shall make application within ninety days of establishing legal residence to become a resident licensee pursuant to R.S. 22:1136. No prelicensing education or examination shall be required of that person to obtain any line of authority previously held in the prior state except where the commissioner of insurance determines otherwise by regulation.

C. The following resident applicants shall be exempt from the requirement of an examination:

(1) Any applicant for a license covering the same line or lines of insurance for which the applicant was licensed under a similar license in this state, other than a temporary license, within five years from the date of expiration of the previous license, unless such previous license was revoked or suspended or renewal was refused by the commissioner.

(2) As to life, health and accident insurance examinations, any applicant who has been conferred the Chartered Life Underwriters (CLU) designation by the American College of Life Underwriters and who is a member in good standing with a local chapter of the American Society of Chartered Life Underwriters.

(3) As to property and casualty insurance examinations, any applicant who has been conferred the Chartered Property and Casualty Underwriter (CPCU) designation by the American Institute for Property and Liability Underwriters, Incorporated, and who is in good standing with a local chapter of the Society of Chartered Property and Casualty Underwriters.

(4) Any applicant for a license to represent an industrial life, health and accident, service, nonprofit, or home service insurer.

(5) Any applicant who shall be licensed to act only as a producer with respect to life, health, and accident insurance on borrowers or debtors, commonly known as credit life or credit health and accident insurance and credit accidental death and dismemberment.

(6) Any applicant who shall be licensed to act only as a producer with respect to credit property and casualty insurance on collateral, commonly known as credit property and casualty insurance, including credit property insurance on which the licensed lender has a security interest, and involuntary unemployment.

(7) Any applicant who is a ticket selling agent of a railroad company, carrier by air, or public bus carrier, who shall act thereunder as an insurance producer only in reference to the issuance of accident or baggage insurance policies in connection with the transportation that accompanies the transportation ticket.

(8) Any applicant who shall be licensed to act only as an automobile club producer to sell a service or membership contract issued by an automobile club.

(9) Producers of any other lines of insurance which the commissioner of insurance determines, by rule or regulation, do not require the professional competency tested by examination.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

§1140. Assumed names

A. An insurance producer doing business under any name other than the producer's legal name is required to notify the commissioner of insurance prior to using the assumed name. Prior to the use of or changes to any trade name or names, an insurance producer shall provide written notification of such use or change to the commissioner, on a form prescribed by the commissioner. A letter of registration from the secretary of state shall accompany the application for a trade name.

B. The use by any insurance producer of a nonapproved trade name shall subject such person to a fine not exceeding two hundred fifty dollars. Additionally, if the insurance producer continues to utilize a nonapproved trade name for ten or more days after being notified by the commissioner to cease using the nonapproved trade name, the insurance producer will be subject to an additional fine not to exceed five thousand dollars. If applicable, an insurance producer must comply with the provisions of R.S. 51:281 et seq.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

§1141. Temporary licensing

A. The commissioner of insurance may issue a temporary insurance producer license for a period not to exceed one hundred eighty days without requiring an examination if the commissioner deems that the temporary license is necessary for the servicing of an insurance business in the following cases:

(1) To the surviving spouse or next of kin, or to the administrator or executor or employee of a licensed insurance producer who is deceased, or to the spouse, next of kin, employee, legal guardian, or other court-appointed personal representative of a licensed insurance producer who becomes mentally or physically disabled, to allow adequate time for the sale of the insurance business owned by the producer, or for the recovery or return of the producer to the business, or to provide for the training and licensing of new personnel to operate the producer's business.

(2) To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license.

(3) To the designee of a licensed insurance producer entering active service in the armed forces of the United States of America.

(4) In any other circumstance where the commissioner deems that the public interest will best be served by the issuance of this license.

B. The commissioner of insurance may by order limit the authority of any temporary licensee in any way deemed necessary to protect insureds and the public. The commissioner may require the temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all acts of the temporary licensee, and may impose other similar requirements designed to protect insureds and the public. The commissioner may by order revoke a temporary license if the interest of insureds or the public are endangered. A temporary license may not continue after the owner or the personal representative disposes of the business.

C.(1) The authority to act as a home service life insurance producer shall be granted to an applicant by the commissioner for a time period to commence with the date of certified mailing of the license application by the insurer and shall terminate upon the issue or denial of a permanent license. The sponsoring insurer must certify that the applicant will be primarily engaged in the selling and servicing of guaranteed life insurance products on the basis set forth in the home service marketing distribution system as defined in Paragraph (2) of this Subsection. The insurer must have a reasonable expectation that the applicant meets the requirements for licensure set forth in R.S. 22:1136(A). For the purpose of limiting the authority contained herein, a guaranteed life insurance product means a policy in which the premiums, face amount of coverage, and nonforfeiture values, if any, are guaranteed at issue by its provisions.

(2) "Home service marketing distribution system" means a system of marketing insurance products in which fifty percent or more of the premium income is derived from policies of insurance which are sold, serviced, or collected by producers visiting in the home or business of the insured, owner, or premium payor and in which policies are issued on a monthly or more frequent premium payment basis or by single premium payment and in which the producer is charged and debited with the responsibility for collection of the premium payments.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

§1142. License denial, nonrenewal, or revocation

A. The commissioner of insurance may place on probation, suspend, revoke, or refuse to issue, renew, or reinstate an insurance producer license, or may levy a fine not to exceed five hundred dollars for each violation occurring, up to ten thousand dollars aggregate for all violations in a calendar year per applicant or licensee, or any combination of actions, for any one or more of the following causes:

(1) The failure to comply with any prerequisite of state or federal law or regulations for the issuance of such license.

(2) Providing incorrect, misleading, incomplete, or materially false information, or omission of material information, in the license or renewal application.

(3) The failure to account for or remit any premiums, monies, or properties belonging to another which come into the possession of the applicant in the course of doing insurance business, or improperly withholding, misappropriating, converting, or failing to timely remit any premiums, monies, or properties received in the course of doing insurance business, whether such premiums, monies, or properties belonging to policyholders, insurers, beneficiaries, claimants, or others.

(4) Using fraudulent, coercive, or dishonest practices or misrepresentation, or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business such as might endanger the public.

(5) Misrepresenting the terms of an actual or proposed insurance contract, binder, rider, plan, or application for insurance, including all forms or documents that are attached, or will be attached, to an actual or proposed insurance contract, binder, rider, plan, or application for insurance.

(6) Having admitted or been found to have committed any insurance unfair trade practice under R.S. 22§1211 et seq. or fraud under R.S. 22§1214 et seq.

(7) The conviction or nolo contendere plea to any felony, participation in a pretrial diversion program pursuant to a felony charge, or conviction of any misdemeanor involving moral turpitude or public corruption.

(8) Obtaining or attempting to obtain a license through misrepresentation or fraud, or improperly using notes or any other reference material to complete an examination for an insurance license, or otherwise cheating or attempting to cheat on an examination for an insurance license of any kind.

(9) The adjudication of bankruptcy with debts related to the receipt or transmittal of insurance premiums or other funds to an insurer or insured in any fiduciary capacity of the applicant, or issuance to the Department of Insurance of an insufficient fund or no-fund check.

(10) Forging another's name to an application for insurance or to any document related to an insurance transaction.

(11) Knowingly accepting insurance business from a person who is not licensed as a producer.

(12) The procurement of a license for the purpose of writing controlled business, as prohibited in this Part.

(13) Having an insurance producer license, or its equivalent, denied, suspended, or revoked in this or any other state, province, district, or territory.

(14) The violation of any insurance laws of the United States, this state or any state, province, district, or territory, or violating any lawful rule, regulation, subpoena, or order of the commissioner of insurance or of the insurance officials of another state.

(15) The refusal to submit physical evidence of identity or the conviction of a felony, in accordance with R.S. 22:1241.1(B) and (C).

(16) The failure to comply with an administrative or court order imposing a child support obligation.

(17) The failure to pay state income taxes or comply with any administrative or court order directing payment of state income taxes.

(18) A producer has employed or has allowed to associate with his business, in any manner, any person engaged in the business of insurance who has been convicted of a felony under the laws of this state or any, the United States, or any foreign country. As used in this Section, business of insurance means the writing of insurance or the reinsuring of risks by an insurance producer or insurer, including all acts necessary or incidental to such writing or reinsuring, and the activities of persons who act as, or are, officers, directors, agents, or employees of producers or insurers, or who are other persons authorized to act on behalf of such persons.

(19) The conviction of a felony involving dishonesty or breach of trust pursuant to 18 U.S.C. 1033 and 1034, without written consent from the commissioner of insurance pursuant to 18 U.S.C. 1033, or any successor statute regulating crimes by or affecting persons engaged in the business of insurance whose activities affect interstate commerce.

B. If the commissioner denies any application for a license, the commissioner shall notify the applicant and advise the applicant in writing of the reasons for the denial. Within thirty days of receipt of notification of denial, the applicant may make written demand to the commissioner for a hearing on the matter of denial.

C. In the event the commissioner suspends or revokes a license, or refuses the renewal or reinstatement of a license, or levies a fine, with or without suspension, revocation, or refusal to renew a license, the commissioner shall notify the licensee in writing of the determination. Any such suspension or revocation of a license, or refusal to renew or reinstate a license, shall include all lines of insurance for which the licensee was authorized. Within thirty days of receipt of notification of denial, the licensee may make written demand to the commissioner for a hearing to seek a reversal of the determination by the commissioner.

D. The license of a business entity may be suspended or revoked, or renewal or reinstatement thereof may be refused, or a fine may be levied, with or without a suspension, revocation, or refusal to renew a license, if the commissioner finds, after a hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers, or managers acting on behalf of the business entity and the violation was not reported to the Department of Insurance and no corrective action was undertaken timely. Any such suspension or revocation of a license, or refusal to renew or reinstate a license, shall include all lines of insurance for which the licensee was authorized.

E.(1) No licensee whose license has been revoked under this Section shall be entitled to file another application for a license within one year from the effective date of such revocation, or, if judicial review of such revocation is sought, within five years from the date of final court order or decree affirming such revocation. A subsequent application, when filed, may be refused by the commissioner of insurance unless the applicant shows good cause why the revocation of his license should not be deemed a prohibition to the issuance of a new license.

(2) Any license which has been reissued following revocation shall be revoked for a period not to exceed five years upon a second violation by the licensee of any of the provisions of this Section. No licensee whose license has been revoked under this Subsection shall be entitled to file another application for a license within the revocation period. A subsequent application, when filed, may be refused by the commissioner of insurance unless the applicant shows good cause why the revocation of his license should not be deemed a prohibition to the issuance of a new license.

F. The commissioner of insurance shall promptly notify all appointing insurers, where applicable, with copies of such notification sent to the licensee, regarding any suspension, revocation, or termination of license by the commissioner.

G. Upon suspension, revocation, or termination of the license of a resident of this state, the commissioner shall notify the support and services office of the National Association of Insurance Commissioners and the proper insurance official of each state for whom the commissioner has executed a certificate as provided for herein.

H. If the commissioner revokes or suspends any nonresident's license through a proceeding under this Part, he shall promptly notify the appropriate insurance official of the licensee's place of residency of such action and of the particulars thereof.

I. The commissioner of insurance shall retain the authority to enforce the provisions of, and impose any penalty or remedy authorized by, this Part against any person who is under investigation for or charged with a violation of this Part, even if the person's license has been surrendered or has lapsed by operation of law.

J. Without in any way limiting or affecting any other civil or criminal remedies or consequences, any person who intentionally withholds or intentionally fails to timely remit premium payments, or who knowingly converts to his own use or benefit any premiums, monies, or other property belonging to any person or entity who applies for insurance through him, or policyholder, beneficiary, or any other claimant under or relating to any insurance policy, shall be guilty of the crime of theft under R.S. 14:67 if he had the intent to permanently deprive the rightful owner of the premiums, monies, or other property, or the crime of unauthorized use of a movable under R.S. 14:68 if he had no intent to permanently deprive the rightful owner of said premiums, monies, or other property.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002; Acts 2003, No. 293, §1.

§1142.1. License to solicit or transact bail; prohibited activities

A. A bail licensee shall not directly or indirectly permit any person, including an employee, to sign or execute a power of attorney or to effect the undertaking of bail for the release of a defendant or to apprehend or surrender a defendant on his behalf unless the person is properly licensed by the commissioner to perform such acts. This Section shall not prevent a bail bond producer from using mail, messenger or delivery service to file executed undertakings of bail or deliver bail bonds, nor shall it prevent such filing or delivery by the attorney or other agent of the defendant.

B. A bail licensee shall not directly or indirectly give a gift of any kind to a prisoner of a jail or place of detention or to a public official or employee of a governmental agency whose duties, functions or responsibilities include the administration of justice.

C. Upon first violation, a person or entity that violates Subsection A of this Section shall be subjected to a six month suspension of their license to write or solicit bail and fined an amount not to exceed five thousand dollars. A second or any subsequent violation shall subject the person or entity to a suspension of their license to write or solicit bail for not more than one year and a fine not to exceed ten thousand dollars. A hearing may be requested pursuant to the provisions of Part XXIX of this Title, subject to the provisions of Chapter 13-B of Title 49 of the Louisiana Revised Statutes of 1950.

D. A person or entity that violates Subsection B of this Section shall be fined an amount not to exceed five thousand dollars for each violation. A hearing may be requested pursuant to the provisions of Part XXIX of this Title, subject to the provisions of Chapter 13-B of Title 49 of the Louisiana Revised Statutes of 1950.

Acts 2003, No. 497, §1, eff. June 20, 2003.

§1143. Commissions

A.(1) An insurer or insurance producer shall not pay, directly or indirectly, any commission, service fee, brokerage, or other valuable consideration to any person or entity for selling, soliciting, or negotiating insurance in this state unless such person or entity holds a valid license as required by law.

(2) No person or business entity other than a person or business entity duly licensed by the Department of Insurance as an insurance producer shall accept any commission, service fee, brokerage, or other valuable consideration for selling, soliciting, or negotiating insurance in this state.

(3) Renewal or other deferred commissions may be paid to a person for selling, soliciting, or negotiating insurance in this state if the person was required to be licensed under this Part at the time of the sale, solicitation, or negotiation and was so licensed at that time.

B.(1) No member of an insurance advisory committee of any state agency, board, commission, or of any political subdivision of this state, including but not limited to school boards, levee boards, deep water port commissions, deep water port, harbor and terminal districts, and the Louisiana Stadium and Exposition District, shall split, pass on, or share with any insurance producer or other person who is not a member of his own firm or corporation and is not a member of said insurance advisory committee, all or any portion of the commission derived by such committee from the purchase of insurance by such state agency, board, commission, or political subdivision of the state without express authorization by official action of such state agency, board, commission, or political subdivision of the state. Any insurance producer or other person who is not a member of such firm or corporation and is not a member of said insurance advisory committee who receives without authorization all or any portion of such commission shall also be in violation of this Subsection.

(2) Any violator of the provisions of this Subsection shall, upon conviction, be fined not less than one thousand dollars, nor more than five thousand dollars per violation, or imprisoned for not more than two years, or both.

(3) Any conviction for a violation of the provisions of this Subsection shall constitute grounds for suspension or revocation by the commissioner of insurance of the license of such insurance producer, in addition to those grounds of R.S. 22:1142.

Acts 2001, No. 158, §1, eff. Jan.1, 2002.

§1144. Appointments

A.(1) An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer, except for surplus lines policies placed through licensed surplus lines brokers, surplus lines policies placed with unauthorized insurers by licensed surplus lines brokers, and workers' compensation policies placed with the Louisiana Workers' Compensation Corporation.

(2) An insurance producer who is not acting as an agent of an authorized insurer is not required to become appointed.

(3) An insurance producer who is duly empowered and authorized to act through or on behalf of another licensed insurance producer in the sale, solicitation, or negotiation of insurance shall not be required to become appointed for the sale, solicitation, or negotiation so conducted.

B.(1) An insurer lawfully authorized to transact business in this state shall appoint as its agent any person or persons holding a license issued under the provisions of this Part. To appoint a producer as its agent, the appointing insurer shall file, in a manner prescribed by the commissioner of insurance, a notice of appointment within fifteen days from the date the agency contract is executed. An insurer may also elect to appoint a producer to all or some insurers within the insurer's holding company system or group by the filing of a single appointment request.

(2) Upon receipt of the notice of appointment, the commissioner shall verify within a reasonable time, not to exceed thirty days, that the insurance producer is eligible for appointment. If the producer is determined to be ineligible for appointment, the commissioner shall notify the insurer within fifteen days of such determination.

(3) Each insurer shall submit to the commissioner of insurance, in a manner prescribed by the commissioner, a list of appointed producers which it intends to appoint or reappoint. Each insurer shall remit, in a manner prescribed by the commissioner, appointment fees in the amount set forth in R.S. 22:1078. Any insurer who fails to file its renewal company appointments will be fined ten dollars per license named in its appointment form, or as otherwise authorized by R.S. 22:1078.

(4) An appointment as provided herein shall remain in full force and effect until the following date of recordation, unless the license of the appointed producer named therein is revoked by the commissioner as provided for in this Part, or until canceled by the insurer upon written notice to the producer with a copy thereof filed with the commissioner.

(5) The duties of the commissioner provided for in this Subsection shall be performed by the commissioner or employees of the department and may not be the subject of any contract for services with any person or entity outside of the department.

C. Any insurance producer, unless otherwise prohibited by contract, licensed in this state, may solicit, negotiate, or effect applications for policies of insurance with any insurer lawfully doing business in this state, other than an insurer such producer is licensed to represent, if such producer is under contract with such insurer. However, no commissions shall be paid by such company to the producer until such time as notice of recordation of the appointment with respect to such producer has been received by the producer from the commissioner.

D. If any producer is operating or intends to operate its business affairs as a partnership, corporation, or other business entity, the appointments herein may be issued by an insurer in the name of such partnership, corporation, or other business entity, upon application, to be licensed as an insurance producer under this Part, provided all persons in said partnership, corporation, or other business entity actively engaged in soliciting, negotiating, or effecting contracts of insurance or renewals thereof also hold an unexpired producer's license issued in accordance with the provisions of this Part.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

§1145. Notification to commissioner of termination

A. An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with a producer for any reason not set forth in R.S. 22:1142, shall notify the commissioner of insurance within thirty days following the effective date of the termination, in a manner prescribed by the commissioner, stating the circumstances of the termination. Upon written request of the commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination.

B. An insurer or authorized representative of the insurer that terminates the appointment, employment, contract, or other insurance business relationship with a producer shall notify the commissioner of insurance within fifteen days following the effective date of the termination, in a manner prescribed by the commissioner, if the reason for termination is one of the reasons set forth in R.S. 22:1142, or the insurer has knowledge the producer was found by a court, government body, or self-regulatory organization authorized by law to have engaged in any of the activities specified in R.S. 22:1142. Upon the written request of the commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination or activity of the producer.

C. The insurer or the authorized representative of the insurer shall promptly notify the commissioner of insurance, in a manner acceptable to the commissioner, if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the commissioner of insurance in accordance with Subsection B had the insurer then known of its existence.

D.(1) Within fifteen days after making any notification required by Subsections A, B, or C, the insurer shall mail a copy of the notification to the producer at his last known address. If the producer is terminated for cause for any of the reasons specified in R.S. 22:1142, the insurer shall provide a copy of the notification to the producer at his last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

(2) Within thirty days after the producer has received the original or additional notification, the producer may file written comments concerning the substance of the notification with the commissioner. The producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a part of the commissioner's file and accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under Subsection F of this Section.

E.(1) In the absence of actual malice, neither insurer, the authorized representative of the insurer, a producer, the commissioner of insurance, nor any organization of which the commissioner is a member and that compiles the information and makes it available to other state insurance officials or regulatory or law enforcement agencies, shall be subject to civil liability, and a civil cause of action of any nature shall not arise against these entities or their respective agents or employees, as a result of any statement or information required by or provided pursuant to this Section or any information relating to any statement that may be requested in writing by the commissioner, from an insurer or producer; or a statement by a terminating insurer or producer to an insurer or producer limited solely and exclusively to whether a termination for cause under Subsection B of this Section was reported to the commissioner, provided that the propriety of any termination for cause under Subsection B of this Section is certified in writing by an officer or authorized representative of the insurer or producer terminating the relationship.

(2) In any action brought against a person or entity that may have immunity under Paragraph (1) of this Subsection for making any statement required by this Section or providing any information relating to any statement that may be requested by the commissioner, the party bringing the action shall plead specifically in any allegation that Paragraph (1) of this Subsection does not apply because the person making the statement or providing the information did so with actual malice.

(3) Nothing in this Section shall abrogate or modify any existing statutory privileges or immunities.

F.(1) Any documents, materials, or other information in the control or possession of the Department of Insurance, furnished by an insurer, producer, or an employee or agent thereof acting on behalf of the insurer or producer, or obtained by the commissioner of insurance in an investigation pursuant to this Section, shall be confidential by law and privileged, shall not be subject to R.S. 44:1 et seq., shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's duties.

(2) Neither the commissioner of insurance nor any person who received documents, materials, or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to Paragraph (1) of this Subsection.

(3) In order to assist in the performance of the commissioner's duties under this Part, the commissioner:

(a) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to Paragraph (1) of this Subsection, with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, with the Office of Disciplinary Counsel of the Louisiana State Bar Association, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information.

(b) May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners or its affiliates or subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(c) May enter into agreements governing sharing and use of information consistent with this Subsection.

(4) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this Section or as a result of sharing as authorized in Paragraph (3) of this Subsection.

(5) Nothing in this Part shall prohibit the commissioner of insurance from releasing final, adjudicated actions, including for cause terminations that are open to public inspection pursuant to R.S. 44:1 et seq., to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries of the National Association of Insurance Commissioners.

G. An insurer, the authorized representative of the insurer, or producer that is found to have reported with actual malice by a court of competent jurisdiction may, after notice and hearing, have its license or certificate of authority suspended or revoked and may be fined in an amount not to exceed five thousand dollars per violation. An insurer, the authorized representative of the insurer, or a producer that fails to report as required under the provisions of this Section may be fined in an amount not to exceed five thousand dollars per violation.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

§1146. Reciprocity

A. The commissioner of insurance shall waive any requirements for a nonresident license applicant with a valid license from his home state, except the requirements imposed by R.S. 22:1138, if the applicant's home state awards nonresident licenses to residents of this state on the same basis.

B. A nonresident producer's satisfaction of his home state's continuing education requirements for licensed insurance producers shall constitute satisfaction of this state's continuing education requirements if the nonresident producer's home state recognizes the satisfaction of its continuing education requirements imposed upon producers from this state on the same basis.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

§1147. Non-reciprocal states or other jurisdictions

Whenever, by the laws or regulations of any other state or jurisdiction, any limitation of rights and privileges, conditions precedent, or any other requirements are imposed upon residents of this state who are nonresident applicants or licensees of such other state or jurisdiction in addition to, or in excess of, those imposed on nonresidents under this Part, the same such requirements shall be imposed upon such residents of such other state or jurisdiction. This Section shall not apply to fees, which shall be as authorized by R.S. 22:1078.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

§1148. Prohibited acts

A.(1) No insurer or insurance producer shall pay any money or commission or brokerage, or give or allow any valuable consideration or compensation to any person or business entity not duly licensed as an insurance producer, nor to an insurer not licensed to do business in this state, for or because of service rendered or performed in this state in selling, soliciting, negotiating, or effecting a contract of insurance on any property or risks, or insurable interests, or business activities located within or transacted within this state. The prohibition of this Subsection shall not apply with respect to any contract of reinsurance.

(2) The prohibition of this Subsection shall not apply to the distribution of profits to the owners of an insurance agency. The provisions of this Paragraph shall not apply to the Louisiana Workers' Compensation Corporation.

B.(1) Whoever violates this Section shall, upon conviction, be fined not less than two thousand dollars, nor more than fifty thousand dollars, or imprisoned with or without hard labor, for not more than three years, or both.

(2) Any conviction for violation of this Section shall constitute grounds for the immediate suspension or revocation by the commissioner of insurance of the license of such insurance producer to sell insurance, in addition to those grounds set forth in R.S. 22:1142.

C.(1) It shall be unlawful for any person or business entity, without conforming to the provisions of this Part, directly or indirectly, to represent himself or itself to be an insurance producer or limited lines producer, or to solicit, negotiate, or effect any contract of insurance or renewal thereof, or to attempt to effect the same on any property, or risk or insurable interests or business activities, located within or transacted within this state. This Subsection shall not apply to:

(a) The clerical duties of office employees not involved in soliciting insurance.

(b) Employees of insurance companies who solicit insurance only for or in conjunction with licensed insurance producers compensated on a commission basis.

(c) The collection of premiums by secretarial or clerical employees of a licensed insurance producer, or other person so authorized by a licensed insurance producer.

(d) Employees of insurance companies who do not solicit insurance but are authorized by their employer to sign policies of insurance.

(2) Wherever the commissioner of insurance determines that a violation of Paragraph (1) of this Subsection has occurred, whether that violation be intentional or not, the commissioner or his designee is hereby authorized to issue an order to cease and desist from the violations complained of, and the commissioner is hereby authorized to seek injunctive relief from the district court of the district in which the violation may have occurred or in any proper venue authorized under the Louisiana Code of Civil Procedure.

D.(1) No person licensed as, or representing himself to be, an insurance producer shall receive anything of value as premium payment or commission for an insurance policy rider, binder, or plan without making a bona fide application to an insurer for an insurance policy.

(2) No person licensed as, or representing himself to be, an insurance producer shall fail to account for or remit any premiums, monies, or properties belonging to another which come into the possession of the applicant in the course of doing insurance business, or improperly withholding, misappropriating, converting, or failing to timely remit any premiums, monies, or properties received in the course of doing insurance business, whether such premiums, monies, or properties belong to policyholders, insurers, beneficiaries, claimants, or others.

E.(1) It shall be unlawful for any insurance producer, directly or indirectly, to collect any insurance premium payment, or compensation, or to solicit, negotiate, effect, procure, receive, or forward any contract of insurance or renewal thereof, in relation to any property or risk or insurable interest in this state, for any insurer not lawfully authorized to transact business in this state, or in any manner to aid or assist in any such transaction, except through licensed surplus lines brokers.

(2) Except as hereinafter provided in Paragraph (3) of this Subsection, any person or business entity shall be liable for the full amount of any loss sustained on any contract of insurance made by or through him or it, directly or indirectly, with any insurer not lawfully authorized to transact business in this state, and for any taxes which may become due under any law of this state by reason of such contract. For purposes of this Section, any surplus lines insurer which is approved by the commissioner shall be considered lawfully authorized to transact business in this state.

(3) Any licensed producer who writes a policy through a licensed surplus lines broker shall not be liable for any losses or taxes as provided for in this Section.

(4) Any person or business entity found to have violated this Part shall be deemed to have engaged in unfair trade practices and shall be subjected to the penalties provided herein. Additionally, any person found to have knowingly and intentionally violated any provisions of this Subsection shall be guilty of a felony and shall be subjected to a term of imprisonment, with or without hard labor, not to exceed five years, on each count, and each day on which a violation of this Subsection occurs shall be considered a separate violation.

F. It shall be unlawful for any producer to sign any policy of insurance endorsement in blank.

G. REPEALED BY ACTS 2001, No. 1158, §3.

H. No insurer, agent, or broker shall accept or process an application for coverage under a Medicare+Choice plan unless the following requirements are met:

(1) The Medicare enrollee or his authorized representative has signed the application for coverage.

(2) The Medicare enrollee is provided a written notice upon transfer from one approved Medicare+Choice plan to another stating that his coverage is being transferred. Such notice shall also state how the change in coverage will impact the Medicare enrollee's access to health care providers, including specifying any known change in health care providers available to provide care.

(3) The Medicare enrollee is provided a written notice upon plan cancellation of his current Medicare+Choice coverage that clearly states the date his coverage ends.

(4) The Medicare enrollee is notified of any known change in health care providers that may reasonably result from the action of the agent or broker.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002; Acts 2001, No. 275, §1, eff. June 1, 2001; Acts 2001, No. 1158, §§1 and 3.

§1149. Reporting of actions

A. An insurance producer shall report to the commissioner of insurance any administrative action taken against the producer in another jurisdiction or by another governmental agency in this state within thirty days of the final disposition of the matter. This report shall include a copy of the order, consent to order, or other relevant legal documents.

B. Within thirty days of a conviction in district court of an offense under R.S. 22:1142(A)(7), a producer shall report such conviction to the commissioner and provide a copy of the bill of information or indictment.

C. Without in any way limiting or affecting any other civil or criminal remedies or consequences, any person who intentionally withholds or intentionally fails to timely report information as required by this Section shall be guilty of violating R.S. 22:1142(A)(14).

Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

§1150. Producers of record

A.(1) Any insurer which issues or delivers a policy or contract of insurance pursuant to the application or request of a producer who is not authorized to represent said insurer as a producer shall be deemed to have authorized such producer as producer of record to act on the insurer's behalf. The payment to such a producer shall be payment to the insurer with all resultant obligations and duties.

(2) This Subsection establishes an agency relationship only for the matter of collection of premiums specifically referred to herein.

B.(1)(a) Any insurance company authorized to transact property, casualty, accident, or health insurance or bond business in this state or issuing or delivering property, casualty, accident, or health insurance, or bonds in this state shall recognize a producer of record when selected by the owner of the policy or the first-named insured if there are multiple-named insureds in writing. The insurer shall recognize the producer of record for purposes of providing quotations or proposals or writing such policies or bonds. The insurer shall retain the producer of record who wrote such policies or bonds for the full term of the contracts or until the renewal date or termination of the contracts, whichever occurs first. The insurer shall not change or remove such producer by any producer of record letter which may be secured by another producer for purposes of providing a quotation or proposal or for writing such policies or bonds during the term of such contracts until the renewal date of the contracts, unless the change or removal is requested by the owner of the policy or the first-named insured if there are multiple-named insureds under a particular contract. In such case, such owner or insured shall select the new producer of record.

(b) If the insurer receives a producer of record letter for an application, the insurer shall provide the producer of record with a quotation or proposal regardless of any other outstanding quotations or proposals. If the quotation or proposal is accepted by the insured, the insurer shall issue the policy with the designated producer of record. If the insurer receives a written request by the insured to change the producer of record on an application, the insurer shall give the initial producer of record written notice fifteen days in advance of the change or removal. If the insurer receives a request to change a producer of record on an application within fifteen days of the policy inception, the insurer shall provide the required fifteen-day notice; however, any required change of producer shall be effective on the inception date of the policy.

(c) If a change or removal of a producer is requested by an insured during a policy period, the insurer shall give the producer written notice fifteen days in advance of the change or removal. If the insurer receives a request to change a producer within the last fifteen days of the policy period, the insurer shall provide the required fifteen-day notice; however, any required change of producer shall be effective on the inception date of the renewal policy.

(d) Property, casualty, and bond commissions shall be paid to the original producer of record at the policy inception for the full term of the policy, unless such policy is written for more than one year or is continuous until canceled, in which case commissions shall be paid to the new producer of record starting on the anniversary rating date when new rates take effect. Accident, health, or benefits commissions shall be paid to the current producer of record and shall change when the producer of record changes.

(2) Except as provided in Paragraph (1) of this Subsection, no insurer or producer shall cancel and rewrite any such contracts during the term of such contract or until the renewal date of the contract, whichever occurs first, which would change the producer of record.

(3) This Subsection shall not apply to any producer who is an employee of an insurer or represents, by contractual agreement, only one insurer or a group of affiliated insurers under R.S. 22:1001 et seq.

(4) Upon the written request of the owner of the policy or the first-named insured if there are multiple-named insureds, an insurer shall permit such owner or insured to select another appointed insurance producer due to the termination, death, or retirement of a producer of record or for any other reason deemed appropriate by such owner or insured. Any renewal commission owed to the former producer of record shall be paid to the new producer of record upon the next renewal of the policy.

(5) Nothing in this Subsection shall require an insurer to conduct business with a producer who is not appointed or otherwise not qualified by the insurer to conduct business with the insurer. However, if the producer is appointed or otherwise qualified by the insurer to conduct business with the insurer, the insurer shall recognize the producer as producer of record under the provisions of this Subsection and shall accord the producer all of the normal rights and privileges of a producer for the insurer.

(6) The commissioner of insurance may promulgate rules to enforce the provisions of this Subsection.

C. The provisions of this Section shall not apply to individually underwritten, guaranteed renewable limited benefit health insurance policies.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002; Acts 2003, No. 378, §1, eff. Jan. 1, 2004.

§1151. Other laws

All laws and parts of laws of this state inconsistent with this Part are hereby superseded with respect to matters covered by this Part.

Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

PART XXV. QUALIFICATION AND LICENSE REQUIREMENTS FOR BROKERS AND AGENTS OTHER THAN LIFE

§1161. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1162. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1163. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1164. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1165. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1166. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1167. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1168. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1169. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1169.1. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1170. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1171. REPEALED BY ACTS 1996, 1st Ex. Sess., No. 71, §2, eff. May 10, 1996.
§1172. REPEALED BY ACTS 1996, 1st Ex. Sess., No. 71, §2, eff. May 10, 1996.
§1173. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1174. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1174.1. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1175. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1175.1. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1176. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1177. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1178. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1179. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1180. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1181. REPEALED BY ACTS 1990, NO. 861, §1.
§1182. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1183. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.

PART XXV-A. PRELICENSE AND CONTINUING EDUCATIONAL PROGRAMS

§1191. Registered insurance agent and bail agent prelicensing program

A.(1) The commissioner shall certify an educational program that meets the requirements of this Part and any rules or regulations promulgated pursuant to this Part as a registered insurance agent or bail agent prelicensing program. Any person who satisfactorily completes an educational program which has been certified as a registered insurance agent or bail agent prelicensing program pursuant to this Part shall satisfy the preexamination educational requirements of R.S. 22:1135(C).

(2) For purposes of this Part, "bail agent" shall mean any person, corporation, or partnership which holds an insurance license and has a contract and an appointment from an insurance company licensed and authorized to provide surety in Louisiana.

B. The commissioner shall promulgate rules and regulations setting forth guidelines and requirements for the content and conduct of a registered insurance agent or bail agent prelicensing program and for the procedure for certification of an instructional program as a registered insurance agent prelicensing program. The commissioner shall also promulgate, after consultation with the Insurance Education Advisory Council, rules and regulations specifying the qualifications which each instructor in a registered insurance agent or bail agent prelicensing program shall possess. All such rules and regulations promulgated by the commissioner shall be promulgated pursuant to the provisions of the Administrative Procedure Act.

C. Each registered insurance agent or bail agent prelicensing program shall be conducted by one of the following:

(1) An insurance trade association;

(2) An insurance company admitted to do business in Louisiana;

(3) An accredited public or private college or university; or

(4) An organization recommended by the Insurance Education Advisory Council and certified by the commissioner of insurance.

D. Each instructor in a registered insurance agent prelicensing program shall possess the qualifications promulgated by the commissioner of insurance for instructors in such programs.

E.(1) Each registered insurance agent prelicensing program for life or health and accident insurance agents shall provide instruction by a qualified instructor in a structured setting with a minimum of sixteen hours of supervised instruction, including instruction in applicable insurance principles, state laws and regulations, and ethical practices.

(2) Each registered insurance agent prelicensing program for insurance agents other than life or health and accident insurance shall provide instruction by a qualified instructor in a structured setting with a minimum of thirty-two hours of supervised instruction, including instruction in applicable insurance principles, state laws and regulations, and ethical practices.

(3) Each registered bail agent prelicensing program shall provide instruction by a qualified instructor in a structured setting with a minimum of eight hours of supervised instruction, including instruction in applicable underwriting principles, state laws and regulations, and ethical practices.

F. While instruction is in progress in a registered insurance agent or bail agent prelicensing program, the instructor shall permit the commissioner, any member of the Insurance Education Advisory Council, and any employee of the Department of Insurance to attend any educational session. Such access shall be for the purpose of monitoring the instruction and program and shall not be disruptive to the instruction. Any person who attends any educational session pursuant to the authority of this Subsection shall do so in an official capacity only. No information or materials shall be used for any personal reasons or gain.

G. The director or supervisor of each registered insurance agent or bail agent prelicensing program shall submit its current course materials to the commissioner of insurance for his review upon his request but no less frequently than every three years.

H. The commissioner may cancel or suspend the certification of any registered insurance agent or bail agent prelicensing program which does not meet the requirements of this Part or of any of the rules or regulations promulgated pursuant to this Part. Such cancellation or suspension shall be made after notice and an opportunity for hearing.

Acts 1988, No. 840, §1, eff. July 18, 1988 (and May 1, 1989); Acts 1992, No. 1039, §1; Acts 1993, No. 142, §1; Acts 1993, No. 952, §4, eff. Jan. 1, 1994, H.C.R. No. 4, 2002 1st Ex. Sess.

§1192. Insurance Education Advisory Council

A. The Insurance Education Advisory Council is hereby created within the Department of Insurance. The council shall be comprised of the commissioner of insurance and eleven other members with experience or training in the field of insurance appointed by the commissioner, subject to confirmation by the Senate, as follows:

(1) Five insurance agents licensed in Louisiana, at least one of whom is appointed from a list of three nominees submitted by each of the following insurance trade associations:

(a) Louisiana Association of Life Underwriters.

(b) Independent Insurance Agents of Louisiana.

(c) Professional Insurance Agents of Louisiana.

(d) Louisiana Surplus Lines Association.

(e) Louisiana Association of Health Underwriters.

(2) Five representatives of insurance companies admitted to do business in Louisiana, at least one of whom is appointed from a list of three nominees submitted by each of the following insurance trade associations:

(a) Louisiana Fire and Casualty Association; and

(b) Louisiana Insurers Conference.

(3) One bail agent from the Association of Louisiana Bail Underwriters.

B. In making the initial appointments, four members shall be appointed for a term of one year, three members shall be appointed for a term of two years, and four members shall be appointed for a term of three years. Thereafter, members shall serve three-year terms. Vacancies shall be filled in the same manner as the original appointment. No member shall serve more than two consecutive three-year terms. Members shall serve without compensation.

C. The council shall review and evaluate each educational program which applies for certification as a registered insurance agent or bail agent prelicensing program. The council shall review and evaluate the course materials, curriculum, and the credentials and qualifications of the instructors. No information or materials reviewed and evaluated by the council may be used for any personal reasons or gain by any member of the council. The council shall make recommendations to the commissioner of insurance with respect to applicants for certification and generally with respect to educational requirements for insurance agents. The council shall perform such other duties related to educational requirements for insurance agents and bail agents as the commissioner may require. The council shall meet at least two times each year and more often as deemed appropriate and necessary.

Acts 1988, No. 840, §1, eff. July 18, 1988 (and May 1, 1989); Acts 1992, No. 1039, §1; Acts 1999, No. 871, §1.

§1193. Continuing education requirements

A. The continuing education requirements for renewal of license under R.S. 22:1137(C)(3) are set forth in this Section. The continuing education requirement shall be fulfilled by satisfactory completion of the required hours of instruction in continuing education programs approved by the commissioner.

B. The commissioner shall promulgate rules and regulations setting forth guidelines and requirements for the content and conduct of continuing education programs and for the procedure for approval of a continuing education program. The commissioner shall also promulgate, with the approval of the Insurance Education Advisory Council, rules and regulations specifying the qualifications which each instructor in an approved continuing education program shall possess. All such rules and regulations promulgated by the commissioner shall be promulgated pursuant to the provisions of the Administrative Procedure Act. The continuing education program shall be conducted by one of the entities set forth in R.S. 22:1191(C).

C. Beginning with renewals effective in 1994, life insurance agents shall complete sixteen hours of approved instruction prior to each renewal of license.

D. Beginning with renewals effective in 1993, insurance brokers, solicitors, and agents authorized to write fire, casualty, or fire and casualty insurance business shall complete twenty-four hours of approved instruction before each renewal of license.

E. For brokers, solicitors, and agents authorized both to write life insurance and to write fire, casualty, or fire and casualty insurance business, the continuing education requirement for renewal of license shall be as follows:

(1) Twelve hours of approved life, health and accident insurance instruction for renewal of the life, health and accident insurance license.

(2) Twenty hours of approved property and casualty instruction for renewal of the property and casualty license.

F.(1) For bail agents and solicitors the continuing education requirement for renewal of license shall be twelve hours of approved bail underwriting instruction.

(2) Within six months after July 1, 1992, the Insurance Education Advisory Council shall accept, upon payment of a fee fixed by the council, applications from bail agents for the prelicensing and continuing educational requirements of this Section without adherence to the requirements herein from any person furnishing due proof that his principal occupation in this state during the year prior to July 1, 1992 was that of a bail agent.

G. No more than ten excess hours of approved property and casualty insurance instruction and no more than six excess hours of approved life, health, and accident insurance instruction accumulated during the previous renewal period may be carried forward and applied to the continuing education requirement for the next renewal period.

H. A person teaching an approved continuing education program shall qualify for the same number of hours of approved instruction as would be granted to a person taking and successfully completing the program.

I.(1)(a) The provisions of this Section, imposing continuing education requirements for renewal of a license, shall not apply to any person sixty-five years of age or older, who has at least fifteen years of experience as a licensed agent, broker, or solicitor, and who either:

(i) Is no longer actively engaged in the insurance business as an agent, broker, or solicitor and who is receiving social security benefits, if eligible.

(ii) Is actively engaged in the insurance business as an agent, broker, or solicitor and who represents or operates through a licensed Louisiana insurer.

(b) The provisions of this Section, imposing continuing education requirements for renewal of a license, shall not apply to any person who is a member of the legislature while that person is serving a term in the legislature.

(2) Every applicant for the exemption provided in this Subsection shall attest to, on forms to be provided by the commissioner, his eligibility for the exemption under this Subsection.

(3) The provisions of Item (1)(a)(i) of this Subsection shall only apply to an individual who retires on or after January 1, 1994.

J. The department may grant continuing education credits to an individual for participating in a qualified graduate-level national designation program only if the individual passes the test required of such program and earns a certificate of completion. Qualified graduate-level national designation programs include programs in which an individual may be designated as a Chartered Life Underwriter (CLU), Chartered Property and Casualty Underwriter (CPCU), Certified Insurance Counselor (CIC), and other such national professional designations.

K. The department may grant four continuing education credits, as determined by the commissioner, to a licensed agent or broker who is a member of, and actively participates in, a state or national insurance association.

L. Beginning with renewals effective in 2006, title insurance agents, licensed pursuant to Part XVI of Chapter 2 of this Title, R.S. 22:2092.1 et seq., shall complete six hours of approved instruction prior to the renewal of the license.

Acts 1989, No. 428, §1; Acts 1990, No. 646, §1; Acts 1992, No. 465, §1; Acts 1992, No. 1000, §1; Acts 1992, No. 1039, §1; Acts 1993, No. 213, §1; Acts 1993, No. 952, §4, eff. Jan. 1, 1994; Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996; Acts 1997, No. 1412, §1, eff. July 15, 1997; Acts 2001, No. 290, §1; Acts 2003, No. 65, §1; Acts 2004, No. 512, §1; Acts 2005, No. 329, §1.

§1194. Louisiana Consortium of Insurance and Financial Services; creation

There is hereby created a public nonprofit unincorporated legal entity known as the "Louisiana Consortium of Insurance and Financial Services". The consortium shall be domiciled at Louisiana State University and Agricultural and Mechanical College at Shreveport. The consortium shall perform its functions under a plan of operation established under R.S. 22:1194.6 and shall exercise its powers through a board of directors with the advice and consent of an advisory committee.

Acts 1995, No. 710, §1, eff. Sept. 1, 1995.

§1194.1. Purpose

The purpose of the consortium shall be to promote the development of academic courses in insurance and financial services, to encourage the establishment of a subspecialty degree program in insurance and financial services, and to develop, promote, and administer continuing education courses and professional development for the insurance industry.

Acts 1995, No. 710, §1, eff. Sept. 1, 1995.

§1194.2. Board of directors

A. The board of directors of the consortium shall consist of eleven persons serving terms as established in the plan of operation. The board shall be composed of five members representing the insurance industry and selected by the Financial Security Study Foundation of Louisiana, Incorporated, two persons selected by the commissioner of insurance, one member selected by the president of the Senate, one member selected by the speaker of the House of Representatives, and two members representing Louisiana State University at Shreveport selected by the chancellor. Legislative members shall serve as ex officio members only.

B. Members of the board shall serve without compensation but may be reimbursed for expenses incurred as members of the board of directors. Legislative members shall receive such per diem and expenses as provided for legislators during attendance of committee meetings.

C. The powers and duties of the board of directors shall be:

(1) To develop, promote, and administer the Louisiana Insurance and Financial Education Consortium.

(2) To provide direction and guidance to the advisory committee.

(3) To report periodically to the commissioner of insurance.

Acts 1995, No. 710, §1, eff. Sept. 1, 1995; Acts 2004, No. 286, §1.

§1194.3. Advisory committee

A. The advisory committee of the consortium shall consist of nineteen members serving terms as established by the plan of operation. The committee shall be composed of:

(1) Thirteen members, representing the administration or the business and insurance faculty of the educational institutions listed below. One person shall be selected from each institution by the chancellor or president:

(a) Grambling State University at Grambling.

(b) Louisiana State University and Agricultural and Mechanical College at Baton Rouge.

(c) Louisiana State University and Agricultural and Mechanical College at Shreveport.

(d) Louisiana Tech University at Ruston.

(e) McNeese State University at Lake Charles.

(f) Nicholls State University at Thibodaux.

(g) Northeast Louisiana University at Monroe.

(h) Northwestern State University at Natchitoches.

(i) Southeastern Louisiana University at Hammond.

(j) Southern University and Agricultural and Mechanical College at Baton Rouge.

(k) Southern University and Agricultural and Mechanical College at Shreveport.

(l) The University of New Orleans.

(m) The University of Southwestern Louisiana at Lafayette.

(2) Six members selected by and representing the following organizations:
(a) Professional Insurance Agents of Louisiana.
(b) Independent Agents of Louisiana.
(c) Louisiana Association of Life Underwriters.
(d) Louisiana Insurers Conference.
(e) Louisiana Fire and Casualty Insurance Association.
(f) Louisiana Association of Independent Colleges and Universities.

B. Members of the committee shall serve without compensation, but may be reimbursed for expenses incurred as members of the committee.

Acts 1995, No. 710, §1, eff. Sept. 1, 1995.

§1194.4. Powers and duties of the consortium

The consortium shall:

(1) Provide direction, oversight, and information to consortium members.

(2) Increase the quality of standards for insurance and financial services practice and education in the state of Louisiana.

(3) Develop and offer to consortium members academic courses and curricula and continuing professional education in insurance and financial services.

(4) Develop means and mechanisms for increasing the public awareness of the issues and concerns of the insurance and financial services industry.

(5) Develop and provide means for delivering credit and noncredit instruction from qualified insurance professors to consortium members.

Acts 1995, No. 710, §1, eff. Sept. 1, 1995.

§1194.5. Powers and duties of the advisory committee

The advisory committee shall:

(1) Under the supervision and guidance of the board of directors, develop and implement policies, practices, and procedures for the daily operation of the consortium.

(2) Plan and implement strategies for the accomplishment of the purpose of the consortium.

(3) Report periodically to the board of directors.

Acts 1995, No. 710, §1, eff. Sept. 1, 1995.

§1194.6. Plan of operation

A.(1) The consortium shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the consortium. The plan of operation and any amendments thereto shall become effective either upon the commissioner's written approval or thirty days after submission if he has not disapproved it.

(2) If the consortium fails to submit a suitable plan of operation within one hundred twenty days following September 30, 1995, or if at any time thereafter the consortium fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Part. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the consortium and approved by the commissioner.

B. The plan of operation shall:

(1) Establish the procedure for the election of officers of the board of directors for the consortium.

(2) Establish procedures whereby all the powers and duties of the consortium and the advisory committee under R.S. 22:1194.2 and 1194.3 will be performed.

(3) Establish the amount and method of reimbursing the members under R.S. 22:1194.2 and 1194.3.

(4) Establish regular places and times for meetings of the board of directors.

(5) Establish procedures for records to be kept of all financial transactions of the consortium, its agents, and the board of directors.

(6) Establish additional provisions necessary or proper for the execution of the powers and duties of the consortium.

Acts 1995, No. 710, §1, eff. Sept. 1, 1995.

§1194.7. Funds

A. The consortium is authorized to apply for, contract for, receive, and expend for its purposes any appropriation or grant from the state, its political subdivisions, the federal government, or any other public or private source.

B. To assist financially with the exercise of the functions and duties provided in R.S. 22:1194.4 and 1194.5, state appropriations are hereby authorized in such amounts as may be necessary.

C. The funds for the operations of the consortium, over and above such funds as are now or may hereafter be made available by law or otherwise may be appropriated by the legislature from the state general fund from year to year.

D. The books and records of the consortium shall be subject to audit by the legislative auditor.

Acts 1995, No. 710, §1, eff. Sept. 1, 1995.

PART XXV-B. MANAGING GENERAL AGENTS LAW

§1201. Title

This Part shall be known and may be cited as the "Managing General Agents Law".

Acts 1990, No. 265, §1, eff. midnight Dec. 31, 1991.

§1202. Definitions

A. "Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

B. "Commissioner" means the commissioner of insurance of this state.

C. "Insurer" means any person, firm, association, or corporation duly licensed in this state as an insurer pursuant to this Chapter.

D.(1) "Managing General Agent" (MGA) means any person, firm, association, or corporation who manages all or part of the insurance business of an insurer, including the management of a separate division, department, or underwriting office, and acts as an agent for such insurer whether known as a managing general agent, manager, or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five percent of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year together with one or more of the following:

(a) Adjusts or pays claims in excess of an amount determined by the commissioner; or

(b) Negotiates reinsurance on behalf of the insurer.

(2) Notwithstanding the above, the following persons shall not be considered as MGAs for the purposes of this Part:

(a) An employee of the insurer.

(b) A United States manager of the United States branch of an alien insurer.

(c) An underwriting manager, which, pursuant to contract, manages all the insurance operations of the insurer, is under common control with the insurer, subject to the Holding Company Regulatory Act,* and whose compensation is not based on the volume of premiums written.

(d) The attorney authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney.

E. "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

F. "Producer" means a person currently licensed as a property and casualty agent, in accordance with the provisions of this Title, who is properly appointed to represent the insurer for the lines of insurance for which he is performing the duties of a managing general agent as defined herein.

Acts 1990, No. 265, §1, eff. midnight Dec. 31, 1991; Acts 1993, No. 189, §1.

*As Appears in the enrolled bill.

§1203. Licensure; registration

A. No person, firm, association, or corporation shall act in the capacity of an MGA with respect to risks located in this state for an insurer licensed in this state unless such person is a licensed producer in this state.

B. No person, firm, association, or corporation shall act in the capacity of an MGA representing an insurer domiciled in this state with respect to risks located outside this state unless such person is licensed as a resident or nonresident producer in this state pursuant to the provisions of this Part.

C. The commissioner may require a bond in an amount of ten percent of the MGA annual writings or two hundred fifty thousand dollars, whichever is less, for the protection of the insurer.

D. No person, firm, association, or corporation shall act in the capacity of an MGA in this state unless such person, firm, association, or corporation has registered his name, current residential address, current mailing address, and current business address with the commissioner, on forms prescribed by the commissioner, together with a fee in the amount set forth in R.S. 22:1078.

E. Each year prior to May first, every MGA shall notify the commissioner of his desire to continue his registration as an MGA on forms prescribed by the commissioner together with a fee in the amount set forth in R.S. 22:1078.

F. If a person, firm, association, or corporation fails to provide any of the information required under this Section, the commissioner may, after notification by the commissioner to the person, firm, association, or corporation by certified mail of such failure, impose a fine not to exceed fifty dollars.

G. The commissioner may require the MGA to maintain an errors and omissions insurance policy.

Acts 1990, No. 265, §1, eff. midnight Dec. 31, 1991; Acts 1991, No. 736, §1; Acts 1993, No. 189, §1; Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996.

§1204. Required contract provisions

No person, firm, association, or corporation acting in the capacity of an MGA shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party and, when both parties share responsibility for a particular function, specifies the division of such responsibilities, and which contains the following minimum provisions:

A. The insurer may terminate the contract for cause upon written notice to the MGA. The insurer may suspend the underwriting authority of the MGA during the pendency of any dispute regarding the cause for termination.

B. The MGA shall render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis.

C. All funds collected for the account of an insurer shall be held by the MGA in a fiduciary capacity in a bank which is a member of the Federal Reserve System. This account shall be used for all payments on behalf of the insurer. The MGA may retain no more than three months' estimated claims payments and allocated loss adjustment expenses.

D. Separate records of business written by the MGA shall be maintained. The insurer shall have access and right to copy all accounts and records related to its business in a form usable by the insurer, and the commissioner shall have access to all books, bank accounts, and records of the MGA in a form usable to the commissioner. Such records shall be retained pursuant to rules and regulations promulgated by the commissioner.

E. The contract may not be assigned in whole or part by the MGA.

F. Appropriate underwriting guidelines including:

(1) The maximum annual premium volume.

(2) The basis of the rates to be charged.

(3) The types of risks which may be written.

(4) Maximum limits of liability.

(5) Applicable exclusions.

(6) Territorial limitations.

(7) Policy cancellation provisions.

(8) The maximum policy period.

G. The insurer shall have the right to cancel or nonrenew any policy of insurance pursuant to the laws and regulations applicable thereto.

H. If the contract permits the MGA to settle claims on behalf of the insurer:

(1) All claims shall be reported to the company in a timely manner.

(2) A copy of the claim file shall be sent to the insurer at its request or as soon as it becomes known that the claim:

(a) Has the potential to exceed an amount determined by the commissioner or exceeds the limit set by the company, whichever is less;

(b) Involves a coverage dispute;

(c) May exceed the MGA's claims settlement authority;

(d) Is open for more than six months; or

(e) Is closed by payment of an amount set by the commissioner or an amount set by the company, whichever is less.

(3) All claim files shall be the joint property of the insurer and MGA. However, upon an order of liquidation of the insurer, files shall become the sole property of the insurer or its estate. The MGA shall have reasonable access to and the right to copy the files on a timely basis.

(4) Any settlement authority granted to the MGA may be terminated for cause upon the insurer's written notice to the MGA or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

I. When electronic claims files are in existence, the contract shall address the timely transmission of the data.

J. If the contract provides for a sharing of interim profits by the MGA, and the MGA has the authority to determine the amount of the interim profits by establishing loss reserves, controlling claim payments, or in any other manner, interim profits shall not be paid to the MGA until one year after they are earned for property insurance business and five years after they are earned for casualty business and not until the profits have been verified pursuant to R.S. 22:1205 of this Part.

K. The MGA shall not:

(1) Bind reinsurance or retrocessions on behalf of the insurer, except that the MGA may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for reinsurance both assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules.

(2) Commit the insurer to participate in insurance or reinsurance syndicates.

(3) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of insurance for which he is appointed.

(4) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed one percent of the insurer's policyholder's surplus as of December thirty-first of the last completed calendar year.

(5) Collect any payment from a reinsurer or commit the insurer to any claims settlement with a reinsurer, without prior approval of the insurer. If prior approval is given, a report shall be promptly forwarded to the insurer.

(6) Permit its subproducer to serve on its board of directors.

(7) Appoint a sub-MGA.

(8) Jointly employ an individual who is employed with the insurer.

Acts 1990, No. 265, §1, eff. midnight Dec. 31, 1991; Acts 1993, No. 189, §1.

§1205. Duties of insurers

A. If an insurer has an MGA who writes more than five percent of its policyholder surplus, then the insurer shall provide financial data by an independent examiner concerning that company's book of business which is in question and is handled by that MGA upon request, and the insurer shall have on file an independent financial examination, in a form acceptable to the commissioner, of each MGA with which it has done business.

B. If an MGA establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA. This is in addition to any other required loss reserve certification.

C. The insurer shall periodically, but no less often than semi-annually, conduct an on-site review of the underwriting and claims processing operations of the MGA.

D. Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who shall not be affiliated with the MGA.

E. Within thirty days of entering into or termination of a contract with an MGA, the insurer shall provide written notification of such appointment or termination to the commissioner. Such notice of appointment of an MGA shall include a statement of duties which the applicant is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act, and any other infomation the commissioner may request. A fee in the amount set forth in R.S. 22:1078 shall accompany an MGA appointment request. If an insurer fails to provide any of the information required under this Subsection, the commissioner may, after he notifies the insurer, by certified mail, impose a fine not to exceed fifty dollars.

F. An insurer shall review its books and records quarterly to determine if any producer has become an MGA as defined in R.S. 22:1202(D). If the insurer determines that a producer has become an MGA, the insurer shall promptly notify the producer and the commissioner of such determination and the insurer and producer shall fully comply with the provisions of this Part within thirty days.

G. Prior to May first annually, each insurer shall notify the commissioner, on a form prescribed by the commissioner, of each MGA it wishes to appoint, accompanied by the fee set forth in R.S. 22:1078.

H. All such appointments shall remain in full force and effect until April thirtieth of the following year unless:

(1) The license of the MGA is revoked or suspended by the commissioner as provided for in this Part or as prescribed in R.S. 22:1142.

(2) The insurer has cancelled the appointment upon written notice to the agent and to the commissioner.

I. Any appointment of an MGA by an insurer received by the commissioner between April fifteenth and April thirtieth shall be effective May first.

J. An insurer shall not appoint to its board of directors an officer, director, employee, subproducer, or controlling shareholder of its MGA's. This Subsection shall not apply to relationships governed by R.S. 22:1001 et seq., or, if applicable, R.S. 22:1201 et seq.

Acts 1990, No. 265, §1, eff. midnight Dec. 31, 1991; Acts 1993, No. 189, §1, H.C.R. No. 4, 2002 1st Ex. Sess, H.C.R. No. 4, 2002 1st Ex. Sess.

§1206. Examination authority

The acts of the MGA are considered to be the acts of the insurer on whose behalf it is acting. An MGA may be examined as if it were the insurer.

Acts 1990, No. 265, §1, eff. midnight Dec. 31, 1991.

§1207. Penalties; suspension, revocation, fines, and liabilities

A. If the commissioner finds after a hearing conducted in accordance with Part XXIX of this Chapter, R.S. 22:1351 et seq., that any person has violated any provision of this Part, the commissioner may order:

(1) For each separate violation, a fine in an amount of five thousand dollars.

(2) Revocation or suspension of the producer's license.

(3) The MGA to reimburse the insurer or the rehabilitator or liquidator of the insurer for any losses incurred by the insurer caused by a violation of this Part committed by the MGA.

B. The decision, determination, or order of the commissioner pursuant to Subsection A of this Section shall be subject to judicial review pursuant to Part XXIX of this Chapter, R.S. 22:1351 et seq.

C. Nothing contained in this Part is intended to or shall be construed to in any manner limit or restrict the rights of policyholders, claimants, and auditors.

Acts 1990, No. 265, §1, eff. midnight Dec. 31, 1991; Acts 1993, No. 189, §1.

PART XXV-C. BUSINESS TRANSACTED WITH BROKER CONTROLLED INSURER LAW

§1210.1. Title

This Part shall be known and may be cited as the "Business Transacted with Broker Controlled Insurer Law".

Acts 1992, No. 811, §1.

§1210.2. Definitions

As used in this Part, the following terms shall have the respective meanings hereinafter set forth, unless the context shall otherwise require:

(1) "Accredited state" means a state in which the insurance department or regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the National Association of Insurance Commissioners.

(2) "Broker" means an insurance broker as defined in R.S. 22:1162.

(3) "Control" or "controlled" has the meaning as defined in R.S. 22:1002(3).

(4) "Controlled insurer" means a licensed insurer which is controlled, directly or indirectly, by a broker.

(5) "Controlling broker" means a broker who, directly or indirectly, controls an insurer.

(6) "Licensed insurer" or "insurer" means any person, firm, association, or corporation licensed to transact property and casualty insurance business in this state. The following are not licensed insurers for the purposes of this Part:

(a) All risk retention groups as defined in the Superfund Amendments Reauthorization Act of 1986, Pub. L. No. 99-499, 100 Stat. 1613 (1986) and the Risk Retention Act, 15 U.S.C. Section 3901 et seq. (1982 & Supp. 1986) and the Risk Retention Group Law (R.S. 22:2071 et seq.).

(b) All residual market pools and joint underwriting authorities or associations.

(c) All insurers owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks to member organizations and/or group members and their affiliates.

Acts 1992, No. 811, §1.

§1210.3. Applicability

This Part shall apply to licensed insurers as defined in R.S. 22:1210.2, either domiciled in this state or domiciled in a state that is not an accredited state having in effect a law substantially similar to this Part. All provisions of the Insurance Holding Company System Regulatory Law, to the extent they are not superseded by this Part, shall continue to apply to all parties within holding company systems subject to this Part.

Acts 1992, No. 811, §1.

§1210.4. Minimum standards

A. Applicability of Section. (1) The provisions of this Section shall apply if, in any calendar year, the aggregate amount of gross written premium on business placed with a controlled insurer by a controlling broker is equal to or greater than five percent of the admitted assets of the controlled insurer, as reported in the quarterly statement of the controlled insurer filed as of September thirtieth of the prior year.

(2) Notwithstanding Paragraph (1) of this Subsection, the provisions of this Section shall not apply if:

(a) The controlling broker places insurance only with the controlled insurer, or only with the controlled insurer and a member or members of the holding company system of the controlled insurer, or the controlled insurer's parent, affiliate, or subsidiary and receives no compensation based upon the amount of premiums written in connection with such insurance.

(b) The controlling broker accepts insurance placements only from nonaffiliated brokers, and not directly from insureds.

(c) The controlled insurer, except for insurance business written through a residual market facility, accepts insurance business only from a controlling broker, a broker controlled by the controlled insurer, or a broker that is a subsidiary of the controlled insurer.

B. Required contract provisions. A controlled insurer shall not accept business from a controlling broker and a controlling broker shall not place business with a controlled insurer, unless there is a written contract between the controlling broker and the insurer specifying the responsibilities of each party, which contract has been approved by the board of directors of the insurer and contains the following minimum provisions:

(1) The controlled insurer may terminate the contract for cause, upon written notice to the controlling broker. The controlled insurer shall suspend the authority of the controlling broker to write business during the pendency of any dispute regarding the cause for the termination.

(2) The controlling broker shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to, the controlling broker.

(3) The controlling broker shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date shall be fixed so that premiums or installments collected shall be remitted no later than ninety days after the effective date of any policy placed with the controlled insurer under this contract.

(4) All funds collected for the controlled insurer's account shall be held by the controlling broker in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the Federal Reserve System, in accordance with the applicable provisions of the Louisiana Insurance Code. However, the funds of a controlling broker not required to be licensed in this state shall be maintained in compliance with the requirements of the domiciliary jurisdiction of the controlling broker.

(5) The controlling broker shall maintain separately identifiable records of business written for the controlled insurer.

(6) The contract shall not be assigned in whole or in part by the controlling broker.

(7) The controlled insurer shall provide the controlling broker with its underwriting standards, rules and procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling broker shall adhere to the standards, rules, procedures, rates, and conditions, which shall be the same as those applicable to comparable business placed with the controlled insurer by a broker other than the controlling broker.

(8) The contract shall specify the rates and terms of the commissions, charges, and other fees of the controlling broker and the purposes for those charges or fees. The rates of the commissions, charges, and other fees, shall be no greater than those applicable to comparable business placed with the controlled insurer by brokers other than controlling brokers. For purposes of this Paragraph and Paragraph (7) of this Subsection, comparable business shall include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business.

(9) If the contract provides that the controlling broker, on insurance business placed with the insurer, is to be compensated contingent upon the profits of the insurer on that business, then such compensation shall not be determined and paid until at least five years after the premiums on liability insurance are earned and at least one year after the premiums are earned on any other insurance. In no event shall the commissions be paid until the adequacy of the reserves of the controlled insurer on remaining claims has been independently verified pursuant to Subsection C of this Section.

(10) The contract shall specify a limit on the writings of the controlling broker in relation to the surplus and total writings of the controlled insurer. The insurer may establish a different limit for each line or subline of business. The controlled insurer shall notify the controlling broker when the applicable limit is approached and shall not accept business from the controlling broker if the limit is reached. The controlling broker shall not place business with the controlled insurer if he has been notified by the controlled insurer that the limit has been reached.

(11) The controlling broker may negotiate, but shall not bind reinsurance on behalf of the controlled insurer on business the controlling broker places with the controlled insurer, except that the controlling broker may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules.

C. Audit committee. Every controlled insurer shall have an audit committee of the board of directors composed of independent directors. The audit committee shall annually meet with management, the independent certified public accountants of the insurer, and an independent casualty actuary or other independent loss reserve specialist acceptable to the commissioner of insurance to review the adequacy of the loss reserves of the insurer.

D. Reporting requirements. (1) In addition to any other required loss reserve certification, the controlled insurer shall annually, on April first of each year, file with the commissioner an opinion of an independent casualty actuary, or such other independent loss reserve specialist approved by the commissioner, reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end, including losses incurred but not reported, on business placed by the controlling broker.

(2) The controlled insurer shall annually report to the commissioner the amount of commissions paid to the controlling broker, the percentage such amount represents of the net premiums written and comparable amounts and percentage paid to noncontrolling brokers for placements of the same kinds of insurance.

E. Compliance date. Controlled insurers and controlling brokers shall comply with this Section no later than November 1, 1992.

Acts 1992, No. 811, §1.

§1210.5. Disclosure

A. The controlling broker, prior to the effective date of the policy, shall deliver written notice to the prospective insured disclosing the relationship between the controlling broker and the controlled insurer; except that, if the business is placed through another broker, who is not a controlling broker, the controlling broker shall retain in his records a signed commitment from the other broker that such broker is aware of the relationship between the insurer and the controlling broker and that such broker has or will notify the insured.

B. Controlled insurers and controlling brokers shall comply with this Section beginning with all policies written or renewed on and after November 1, 1992.

Acts 1992, No. 811, §1.

§1210.6. Penalties

A. If the commissioner believes that the controlling broker, or any other person, has not materially complied with this Part, or any regulation or order promulgated hereunder, after notice and opportunity to be heard, the commissioner may order the controlling broker to cease placing business with the controlled insurer.

B. If it is found that, because the controlling broker or any other person has not materially complied with this Part, the controlled insurer or any policyholder thereof has suffered any loss or damage, the commissioner may maintain a civil action or intervene in an action brought by or on behalf of the insurer or policyholder for recovery of compensatory damages, for the benefit of the insurer or policyholder, or other appropriate relief.

C. If an order for liquidation or rehabilitation of the controlled insurer has been entered and the receiver appointed pursuant to that order believes that the controlling broker or any other person has not materially complied with this Part, or any regulation or order promulgated hereunder, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

D. Nothing contained in this Section shall affect the right of the commissioner to impose any additional penalties provided in the Louisiana Insurance Code.

E. Nothing contained in this Section is intended to or shall in any manner alter or affect the rights of policyholders, claimants, creditors, or other third parties.

Acts 1992, No. 811, §1.

PART XXV-D. REINSURANCE INTERMEDIARY LAW

§1210.20. Title

This Part may be cited as the "Reinsurance Intermediary Law".

Acts 1992, No. 811, §1.

§1210.21. Definitions

As used in this Part:

(1) "Actuary" shall mean a person who is a member in good standing of the American Academy of Actuaries.

(2) "Controlling person" shall mean any person, firm, association, or corporation who directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of the reinsurance intermediary.

(3) "Insurer" shall mean any person, firm, association, or corporation duly licensed in this state, pursuant to the applicable provisions of the Louisiana Insurance Code, as an insurer.

(4) "Licensed producer" shall mean an agent, broker, or reinsurance intermediary licensed pursuant to the applicable provisions of the Louisiana Insurance Code.

(5) "Reinsurance intermediary" shall mean a reinsurance intermediary-broker or a reinsurance intermediary-manager as these terms are defined in Paragraphs (6) and (7) of this Section.

(6) "Reinsurance intermediary-broker" shall mean any person, other than an officer or employee of the ceding insurer, who solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of such insurer.

(7) "Reinsurance intermediary-manager" shall mean any person, firm, association, or corporation who has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department or underwriting office, and acts as an agent for such reinsurer, whether known as a reinsurance intermediary-manager, manager, or other similar term. Notwithstanding the above, the following persons shall not be considered a reinsurance intermediary-manager, with respect to such reinsurer, for the purposes of this Part:

(a) An employee of the reinsurer.

(b) A United States manager of the United States branch of an alien reinsurer.

(c) An underwriting manager which, pursuant to contract, manages all the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to the Insurance Holding Company System Regulatory Law, and whose compensation is not based on the volume of premiums written.

(d) The manager of a group, association, pool, or organization of insurers which engage in joint underwriting or joint reinsurance and who are subject to examination by the state in which the manager's principal business office is located.

(8) "Reinsurer" shall mean any person, firm, association, or corporation duly licensed in this state, pursuant to the applicable provisions of the Louisiana Insurance Code, as an insurer with the authority to assume reinsurance.

(9) "Qualified United States financial institutions" shall, for purposes of this Part, mean an institution that:

(a) Is organized or licensed under the laws of the United States or any state thereof.

(b) Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

(c) Has been determined by either the commissioner of insurance or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

(10) "To be in violation" shall mean that the reinsurance intermediary, insurer, or reinsurer for whom the reinsurance intermediary was acting failed to substantially comply with the provisions of this Part.

Acts 1992, No. 811, §1.

§1210.22. Licensure

A. No person, firm, association, or corporation shall act as a reinsurance intermediary-broker in this state if the reinsurance intermediary-broker maintains an office either directly or as a member or employee of a firm or association, or as an officer, director, or employee of a corporation:

(1) In this state, unless the reinsurance intermediary-broker is a licensed producer in this state.

(2) In another state, unless the reinsurance intermediary-broker is a licensed producer in this state or another state having a law substantially similar to this Part, or the reinsurance intermediary-broker is licensed in this state as a nonresident reinsurance intermediary.

B. No person, firm, association, or corporation shall act as a reinsurance intermediary-manager:

(1) For a reinsurer domiciled in this state, unless the reinsurance intermediary-manager is a licensed producer in this state.

(2) In this state, if the reinsurance intermediary-manager maintains an office either directly or as a member or employee of a firm or association, or as an officer, director, or employee of a corporation in this state, unless such reinsurance intermediary-manager is a licensed producer in this state.

(3) In another state for a nondomestic insurer, unless such reinsurance intermediary-manager is a licensed producer in this state or another state having a law substantially similar to this Part, or such person is licensed in this state as a nonresident reinsurance intermediary.

C. The commissioner may require a reinsurance intermediary-manager subject to Subsection B of this Section to:

(1) File a bond, from an insurer acceptable to the commissioner, in such amount as the commissioner may determine, for the protection of the reinsurer.

(2) Maintain an errors and omissions policy in such amount as the commissioner may determine.

D.(1) The commissioner may issue a reinsurance intermediary license to any person, firm, association, or corporation who has complied with the requirements of this Part. Any such license issued to a firm or association will authorize all the members of the firm or association and any designated employees to act as reinsurance intermediaries under the license, and all such persons shall be named in the application and any supplements thereto. Any license issued to a corporation shall authorize all of the officers, and any designated employees and directors thereof to act as reinsurance intermediaries on behalf of such corporation, and all such persons shall be named in the application and any supplements thereto.

(2) If the applicant for a reinsurance intermediary license is a nonresident, the applicant, as a condition precedent to receiving or holding a license, shall designate the commissioner as agent for service of process in the manner, and with the same legal effect, provided for by this Part for designation of service of process upon unauthorized insurers, and shall furnish the commissioner with the name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting such nonresident reinsurance intermediary may be served. The licensee shall promptly notify the commissioner, in writing, of every change in its designated agent for service of process, and such change shall not become effective until acknowledged by the commissioner.

E. The commissioner may refuse to issue a reinsurance intermediary license if, in his judgment, the applicant, anyone named on the application, or any member, principal, officer, or director of the applicant, is not trustworthy, or that any controlling person of such applicant is not trustworthy, to act as a reinsurance intermediary, or that any of the foregoing has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the issuance of such license. Upon written request, the commissioner may furnish a summary of the basis for refusal to issue a license, which document shall be privileged and not subject to examination or reproduction as a public record in accordance with R.S. 44:31.

F. Licensed attorneys at law of this state, when acting in their professional capacity as such, shall be exempt from this Section.

Acts 1992, No. 811, §1.

§1210.23. Required contract provisions for reinsurance intermediary-brokers

Any transactions between a reinsurance intermediary-broker and the insurer the broker represents in such capacity shall only be entered into pursuant to a written authorization, specifying the responsibilities of each party. The authorization shall, at a minimum, provide that:

(1) The insurer may terminate the authority of the reinsurance intermediary-broker at any time.

(2) The reinsurance intermediary-broker shall render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing, to the reinsurance intermediary-broker, and remit all funds due to the insurer within thirty days of receipt.

(3) All funds collected for the insurer's account shall be held by the reinsurance intermediary-broker in a fiduciary capacity in a bank which is a qualified United States financial institution as defined herein.

(4) The reinsurance intermediary-broker shall comply with R.S. 22:1210.24.

(5) The reinsurance intermediary-broker will comply with the written standards established by the insurer for the cession or retrocession of all risks.

(6) The reinsurance intermediary-broker shall disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

Acts 1992, No. 811, §1.

§1210.24. Books and records; reinsurance intermediary-brokers

A. For no less than ten years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-broker, the reinsurance intermediary-broker shall keep a complete record for each transaction showing:

(1) The type of contract, limits, underwriting restrictions, classes or risks and territory.

(2) The period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation.

(3) Reporting and settlement requirements of balances.

(4) The rate used to compute the reinsurance premium.

(5) The names and addresses of assuming reinsurers.

(6) The rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-broker.

(7) Any related correspondence and memoranda.

(8) The proof of placement.

(9) Details regarding retrocessions handled by the reinsurance intermediary-broker, including the identity of retrocessionaires and percentage of each contract assumed or ceded.

(10) Financial records, including but not limited to premium and loss accounts.

(11) When the reinsurance intermediary-broker procures a reinsurance contract on behalf of a licensed ceding insurer:

(a) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk.

(b) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative.

B. The insurer shall have access and the right to copy and audit all accounts and records maintained by the reinsurance intermediary-broker to its business in a form usable by the insurer.

Acts 1992, No. 811, §1.

§1210.25. Duties of insurers utilizing the services of a reinsurance intermediary-broker

A. An insurer shall not engage the services of any person, firm, association, or corporation to act as a reinsurance intermediary-broker on its behalf, unless such person is licensed as required by R.S. 22:1210.22(A).

B. An insurer may not employ an individual who is employed by a reinsurance intermediary-broker with which it transacts business, unless such reinsurance intermediary-broker is under common control with the insurer and subject to the Insurance Holding Company System Regulatory Law.

C. The insurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-broker with which it transacts business.

Acts 1992, No. 811, §1.

§1210.26. Required contract provisions for reinsurance intermediary-managers

A. Any transactions between a reinsurance intermediary-manager and the reinsurer represented in its capacity shall only be entered into pursuant to a written contract, specifying the responsibilities of each party, which shall be approved by the board of directors of the reinsurer. At least thirty days before the reinsurer assumes or cedes business through the producer, a true copy of the approved contract shall be filed with the commissioner for approval. The contract shall, at a minimum, provide that:

(1) The reinsurer may terminate the contract for cause upon written notice to the reinsurance intermediary-manager. The reinsurer may immediately suspend the authority of the reinsurance intermediary-manager to assume or cede business during the pendency of any dispute regarding the cause for termination.

(2) The reinsurance intermediary-manager will render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to the reinsurance intermediary-manager, and remit all funds due under the contract to the reinsurer at least monthly.

(3) All funds collected for the account of the reinsurer will be held by the reinsurance intermediary-manager in a fiduciary capacity in a bank which is a qualified United States financial institution as defined herein. The reinsurance intermediary-manager may retain no more than three months estimated claims payments and allocated loss adjustment expenses. The reinsurance intermediary-manager shall maintain a separate bank account for each reinsurer that it represents.

(4) For at least ten years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-manager, the reinsurance intermediary-manager will keep a complete record for each transaction showing:

(a) The type of contract, limits, underwriting restrictions, classes or risks and territory.

(b) Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation, and disposition of outstanding reserves on covered risks.

(c) Reporting and settlement requirements of balances.

(d) Rate used to compute the reinsurance premium.

(e) Names and addresses of reinsurers.

(f) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-manager.

(g) Related correspondence and memoranda.

(h) Proof of placement.

(i) Details regarding retrocessions handled by the reinsurance intermediary-manager, as permitted by R.S. 22:1210.28(D), including the identity of retrocessionaires and percentage of each contract assumed or ceded.

(j) Financial records, including but not limited to premium and loss accounts.

(k) When the reinsurance intermediary-manager places a reinsurance contract on behalf of a ceding insurer:

(i) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk.

(ii) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative.

(5) The reinsurer will have access to and the right to copy all accounts and records maintained by the reinsurance intermediary-manager related to its business in a form usable by the reinsurer.

(6) The contract cannot be assigned in whole or in part by the reinsurance intermediary-manager.

(7) The reinsurance intermediary-manager will comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection or cession of all risks.

(8) Sets forth the rates, terms, and purposes of commissions, charges, and other fees which the reinsurance intermediary-manager may levy against the reinsurer.

B. If the contract permits the reinsurance intermediary-manager to settle claims on behalf of the reinsurer:

(1) All claims shall be reported to the reinsurer in a timely manner.

(2) A copy of the claim file shall be sent to the reinsurer at its request or as soon as it becomes known that the claim:

(a) Has the potential to exceed the lesser of:

(i) An amount determined by the commissioner; or

(ii) The limit set by the reinsurer;

(b) Involves a coverage dispute;
(c) May exceed the claims settlement authority of the reinsurance intermediary-manager;
(d) Is open for more than six months; or
(e) Is closed by payment of the lesser of:
(i) An amount set by the commissioner; or
(ii) An amount set by the reinsurer.

(3) All claim files shall be the joint property of the reinsurer and the reinsurance intermediary-manager. However, upon an order of liquidation of the reinsurer, such files shall become the sole property of the reinsurer or its estate. The reinsurance intermediary-manager shall have reasonable access to and the right to copy such files on a timely basis.

(4) Any settlement authority granted to the reinsurance intermediary-manager may be terminated for cause upon the written notice by the reinsurer to the reinsurance intermediary-manager or upon the termination of the contract. The reinsurer may suspend such settlement authority during the pendency of the dispute regarding the cause of termination.

C. If the contract provides for a sharing of interim profits by the reinsurance intermediary-manager, that such interim profits will not be paid until one year after the end of each underwriting period for property business and five years after the end of each underwriting period for casualty business, or for such longer period as may be specified by the commissioner, and not until the adequacy of reserves on remaining claims has been verified pursuant to R.S. 22:1210.28(C).

D. The reinsurance intermediary-manager shall annually provide the reinsurer with a statement of its financial condition prepared by an independent certified accountant.

E. The reinsurer shall conduct an on-site review of the underwriting and claims processing operations of the reinsurance intermediary-manager, at least semiannually.

F. The reinsurance intermediary-manager will disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with the insurer pursuant to the contract.

G. Within the scope of its actual or apparent authority, the acts of the reinsurance intermediary-manager shall be deemed to be the acts of the reinsurer on whose behalf it is acting.

Acts 1992, No. 811, §1.

§1210.27. Prohibited acts

The reinsurance intermediary-manager shall not:

(1) Cede retrocessions on behalf of the reinsurer, except that the reinsurance intermediary-manager may cede facultative retrocessions pursuant to obligatory facultative agreements, if the contract with the reinsurer contains reinsurance underwriting guidelines for such retrocessions. The guidelines shall include a list of reinsurers with which such automatic agreements are in effect, and for each such reinsurer, the coverages and amounts or percentages that may be reinsured, and commission schedules.

(2) Commit the reinsurer to participate in reinsurance syndicates.

(3) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of reinsurance for which he is appointed.

(4) Without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, minus its retrocessions, that exceeds the lesser of an amount specified by the reinsurer or one percent of the reinsurer's policyholder's surplus as of December thirty-first of the last complete calendar year.

(5) Collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report must be promptly forwarded to the reinsurer.

(6) Jointly employ an individual who is employed by the reinsurer, unless such reinsurance intermediary-manager is under common control with the reinsurer subject to the Insurance Holding Company System Regulatory Law.

(7) Appoint a subreinsurance intermediary-manager.

Acts 1992, No. 811, §1.

§1210.28. Duties of reinsurers utilizing the services of a reinsurance intermediary-manager

A. A reinsurer shall not engage the services of any person, firm, association, or corporation to act as a reinsurance intermediary-manager on its behalf unless such person is licensed as required by R.S. 22:1210.22(B).

B. The reinsurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-manager which such reinsurer has engaged, prepared by an independent certified public accountant in a form acceptable to the commissioner.

C. If a reinsurance intermediary-manager establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the reinsurance intermediary-manager. The opinion shall be in addition to any other required loss reserve certification.

D. The binding authority for all retrocessional contracts, or participation in reinsurance syndicates, shall be borne with an officer of the reinsurer, who shall not be affiliated with the reinsurance intermediary-manager.

E. Within thirty days of termination of a contract with a reinsurance intermediary-manager, the reinsurer shall provide written notification of the termination to the commissioner.

F. A reinsurer shall not appoint to its board of directors any officer, director, employee, controlling shareholder, or subproducer of its reinsurance intermediary-manager. This Subsection shall not apply to relationships governed by the Insurance Holding Company System Regulatory Law or, if applicable, the Business Transacted with Broker Controlled Insurer Law.

Acts 1992, No. 811, §1.

§1210.29. Examination authority

A. Any reinsurance intermediary shall be subject to examination by the commissioner. The commissioner shall have access to all books, bank accounts, and records of the reinsurance intermediary in a form usable to the commissioner.

B. A reinsurance intermediary-manager may be examined as if it were the reinsurer.

Acts 1992, No. 811, §1.

§1210.30. Penalties and liabilities

A. Any reinsurance intermediary, insurer or reinsurer found by the commissioner, after a public hearing held pursuant to the provisions of Part XXIX of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950, to be in violation of any provision of this Part, shall:

(1) For each separate violation, pay a penalty in an amount not exceeding five thousand dollars.

(2) Be subject to revocation or suspension of its license.

(3) If a violation was committed by the reinsurance intermediary, such reinsurance intermediary shall make restitution to the insurer, reinsurer, rehabilitator, or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to such violation.

B. Any person aggrieved by the decision, determination, or order of the commissioner pursuant to Subsection A of this Section may appeal to the Nineteenth Judicial District Court in and for the parish of East Baton Rouge.

C. Nothing contained in this Section shall affect the authority and right of the commissioner to impose any other penalties provided in the Louisiana Insurance Code.

D. Nothing contained in this Part is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors, or other third parties or confer any rights to those persons.

Acts 1992, No. 811, §1.

§1210.31. Rules and regulations

The commissioner may adopt reasonable rules and regulations for the implementation and administration of the provisions of this Part.

Acts 1992, No. 811, §1.

PART XXV-E. THE LOUISIANA PROFESSIONAL EMPLOYER ACT

§1210.51. Purpose

The purpose of this Part is to provide for professional employment services by defining such services, requiring registration of persons or entities providing such services, providing for employee benefits plans and workers' compensation coverage for participants of such services, and providing for enforcement of this Part.

Acts 2001, No. 1150, §1.

§1210.52. Definitions

As used in this Part, the following terms shall have the following definitions:

(1) "Client" means an employer who obtains services or all or a majority of its work force or labor from a professional employer organization.

(2) "Controlling person" means either one of the following:

(a) An officer or director of a corporation, a shareholder holding ten percent or more of the voting stock of a corporation, a general partner of a partnership, or a manager of a limited liability company.

(b) An individual who possesses, directly or indirectly, the power to direct or cause the direction of the management or policies of a person or entity through the ownership of voting stock by written contract.

(3) "Experience rating modification" or "EMOD" means a statistical procedure approved by the Louisiana Insurance Rating Commission, as provided for in R.S. 22:1401 et seq., for use in the calculation of a premium rate based on actual claims and expense experience.

(4) "Independent contractor" means a person who, exercising an independent employment or engaging in an independent business enterprise, contracts to do a piece of work according to his own methods, and without being subject to the control of the person with whom he has contracted, except as to the result of the work, or is otherwise a person who is so defined under R.S. 23:1021(6) or R.S. 23:1472(12)(E).

(5) "Person" means an individual, association, partnership, corporation, limited liability company, or other entity.

(6) "Professional Employer Organization" or "PEO" means any person that offers professional employer services pursuant to a professional employer services agreement with a client, including but not limited to administrative services organizations and employee leasing organizations that provide services pursuant to a PEO agreement.

(7) "Professional employer services agreement" or "PEO Services Agreement" means an agreement between a professional employer organization and a client pursuant to which the PEO assumes the status of employer with respect to a substantial part of a client's workforce and undertakes responsibilities specified in the agreement with respect to those employees covered by the agreement.

(8) "Staffing service" means any person, other than a professional employer organization, that hires its own employees and assigns them to a client to support or supplement the client's workforce, and includes temporary staffing services and leasing companies that supply employees to clients in special work situations such as employee absences, temporary skill shortages, seasonal workloads, and special assignments and projects.

Acts 2001, No. 1150, §1.

§1210.53. Professional employer services agreement requirements

Every professional employer services agreement ("PEO agreement") shall comply with the following requirements:

(1) The agreement shall be in writing and executed by both the PEO and the client.

(2) The agreement shall have an initial term of at least one year or, in the absence of an initial term of one year, the agreement shall clearly indicate that the intent is for the agreement to be ongoing rather than temporary.

(3) The agreement shall provide that the client retains control over its business enterprise and exercises direction and control over the covered employees as to the manner and method of work done in furtherance of the client's business, but that authority and responsibility as to other employment matters, including but not limited to hiring, firing, discipline, and compensation, are allocated to and shall be between the PEO and the client.

(4) The agreement shall specifically provide for and allocate responsibility between the PEO and the client company with regard to the procurement and maintenance of workers' compensation insurance covering their liability for workers' compensation benefits and group health insurance to or with respect to the employees covered by the professional services agreement and with regard to liability for workers' compensation benefits to the employees covered by the professional services agreement.

(5) The agreement shall state specifically that the agreement is executed between the parties subject to the provisions of this Part and Part XII of Chapter 11 of Title 23 of the Louisiana Revised Statutes of 1950.

Acts 2001, No. 1150, §1.

§1210.54. Exemptions; exceptions

A. The provisions of this Part shall not apply to the following:

(1) An agreement to provide services or the services provided by or through any staffing service or independent contractor, or to any arrangement by which employees are shared by a person with a commonly owned company within the meaning of Sections 414(b) and 414(c) of the Internal Revenue Code of 1986, as amended.

(2) An arrangement in which a person assumes responsibility for the product produced or service performed by such person or his agents, and in which that person retains and exercises primary direction and control over the work performed by the individuals whose services are supplied under such arrangements.

(3) A temporary help arrangement whereby an organization hires its own employees and assigns them to a client to support or supplement the client's workforce in special work situations such as employee absences, temporary skill shortages, seasonal workloads, and special assignments and projects.

B. The provisions of this Part shall not prohibit a client that is party to a collective bargaining agreement from contracting with a PEO if the union consents to such agreement. No PEO service agreement shall have any effect on collective bargaining agreements that are in existence prior to the PEO arrangement.

C.(1) Nothing in this Part shall exempt any client of a PEO, or any employee covered by a PEO services agreement, from any license requirements imposed under local, state, or federal law.

(2) A covered employee who is licensed, registered, or certified under law is considered to be an employee of the client for purposes of that license, registration, or certification.

(3) No PEO shall engage in the unauthorized practice of an occupation, trade, or profession that is licensed, certified, or otherwise regulated by a governmental entity solely by entering into a professional employer services agreement with a client or assuming the status of employer for purposes specified in the PEO services agreement with respect to the employees of such a client.

Acts 2001, No. 1150, §1.

§1210.55. Employee benefit plans

A. A PEO may sponsor and maintain employee benefits plans in which its clients have the option to participate. Every employee benefit plan shall comply with applicable state and federal laws.

B.(1) At least ten days before the initiation of coverage under any policy of insurance issued in connection with an employee health benefit plan, the PEO shall submit the policy to the department for its review and authorization for issuance in this state.

(2) If a client participates in such a health benefit plan the client shall submit an application for coverage on forms provided by an insurer authorized to transact business in this state, and the client's employees shall be considered as a separate group for purposes of eligibility, rating, and coverage.

Acts 2001, No. 1150, §1.

§1210.56. Workers' compensation insurance

A. If the PEO service agreement provides for the procurement and maintenance of state or federal workers' compensation insurance, covering the liability of the client, the insurance covering such liability shall be placed with an insurer authorized to transact business in this state and such coverage shall include a plan of multiple coordinated policies in place. Each plan shall comply with the following requirements:

(1) A separate policy shall be issued to each client, covering the client's compensation liability with respect to each of its employees, whether or not covered by the PEO services agreement.

(2) Payroll for all of the client's employees shall be assigned to the policy in the name of the client.

(3) All policies shall be written by an admitted insurer and shall be coordinated and have a common expiration date.

(4) Each individual client policy shall apply the rates, rules, classifications, rating plans, and audit procedures approved by the Louisiana Insurance Rating Commission as provided in R.S. 22:1401, et seq. The experience modification factor shall be calculated using the experience of the client, which factor shall survive termination of the PEO contract, and shall, upon termination of the professional services agreement, be reported separately in accordance with the applicable rating plan.

(5) The PEO may collect from its clients and remit to the carrier premiums on its own and its clients' policies.

B.(1) If coverage for workers' compensation liability is secured, both the PEO and the client shall maintain appropriate evidence of workers' compensation insurance.

(2) Each PEO shall comply with the insurer's reasonable and lawful requests for information pertinent to the insurance, including the name and federal identification number of each client, classification codes, payrolls, information, loss data, and jurisdictions with exposure, and shall submit appropriate audits of its operations. Failure of a PEO to comply with the provisions of this Paragraph, after a reasonable opportunity to cure any deficiency, shall be grounds for cancellation of the workers' compensation insurance policy.

C. Nothing in this Section shall limit the PEO's and client's ability to specify in the PEO services agreement how liability for workers' compensation benefits to employees covered by the PEO services agreement will be apportioned between them. Each shall have the benefit of the exclusive remedy defense under R.S. 23:1032. No PEO shall have the benefit of such exclusive remedy defense by virtue merely of its PEO status or relationship to its clients or to the covered employees in case a covered employee of one client of the PEO injures a covered employee or employee of another client of the same PEO; however, the PEO may maintain the exclusive remedy defense if it is otherwise available under law due to the relationship between the two clients, independent of their relationships with the PEO.

D. Nothing in this Section shall prevent a client from securing a policy of workers' compensation insurance from an insurer authorized to transact business in this state which is outside of the PEO services agreement.

E. The provisions of this Section, relative to guidelines for workers' compensation insurance, shall become effective on January 1, 2002 and shall apply to workers' compensation insurance policies executed or renewed after January 1, 2002; however, the commissioner may delay implementation of the provisions of this Section for a period of not more than ninety days upon a showing of good cause.

Acts 2001, No. 1150, §1, eff. Jan. 1, 2002.

§1210.57. Licensure

Every PEO engaged in the business of soliciting, selling, or negotiating policies of insurance shall be properly licensed in accordance with this Title. The PEO shall not hold itself out as an insurer, insurance broker, or insurance agent; offer any insurance service; or conduct any business that is defined or regulated in this Title unless appropriately licensed. No representative of a PEO shall make any comparative analysis or render advice regarding any insurance policy or coverage, including any health benefit plan or workers' compensation insurance, during the solicitation or sale of a professional employer services agreement or otherwise, unless properly licensed as an insurance agent or insurance broker in accordance with this Title.

Acts 2001, No. 1150, §1.

§1210.58. Registration

Each person operating in this state as a PEO shall have on file with the department a statement, on a form to be prescribed by the department, of its name, its registered address, the address of its principal business establishments inside and outside this state, its telephone and facsimile number, the form of business entity it has assumed, the state of its incorporation or other organization, the name of a principal contact person, and the names and addresses of all controlling persons. Such statements shall be renewed annually. The department shall maintain such statements and make them available to the public as any other public document. The department may charge such a fee on submission of such statements as is necessary to cover its costs in receiving and maintaining them, not to exceed five hundred dollars for the initial registration and three hundred dollars for annual renewals.

Acts 2001, No. 1150, §1.

§1210.59. Enforcement

The provisions of this Part may be enforced by the commissioner pursuant to R.S. 22:1215 through 1217.1 and other applicable provisions of this Title.

Acts 2001, No. 1150, §1.

§1210.60. Implementation

The department may promulgate such rules and regulations, pursuant to the Administrative Procedure Act, as are necessary to implement this Part.

Acts 2001, No. 1150, §1.

§1210.61. Registration forms; submissions

A. Each PEO operating in the state prior to or on September 1, 2001, shall submit a registration form to the Department of Insurance by October 30, 2001, and to the Department of Labor by January 31, 2002, or within thirty days after the registration form is made available by the respective departments, whichever is later.

B. Any PEO which commences operations after September 1, 2001, shall submit a completed registration form to the Department of Insurance and the Department of Labor in advance of commencing operation in this state or within thirty days after such form is made available by the respective departments, whichever is later.

Acts 2001, No. 1150, §3.

PART XXVI. UNFAIR TRADE PRACTICES

§1211. Purpose

The purpose of this Part is to regulate the trade practices in the business of insurance, in accordance with the intent of congress as expressed in Public Law 15-79th Congress*, by defining or providing for the determination of all acts, methods, and practices which constitute unfair methods of competition and unfair or deceptive acts and practices in this state, and to prohibit the same.

Acts 1958, No. 125; Acts 1993, No. 953, §1.

*15 U.S.C.A. §§1011 to 1015.

§1212. Definitions

When used in this Part:

A. "Commissioner" means the commissioner of insurance of this state.

B. "Insured" means the party named on a policy or certificate as the individual with legal rights to the benefits provided by such policy.

C. "Insurer" means any person, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society, industrial and burial insurer, or any insurer that markets under the Home Service Marketing distribution method and issues a majority of its policies on a weekly or monthly basis, or any other legal entity engaged in the business of insurance, including insurance agents, insurance brokers, surplus lines brokers, and insurance solicitors. Insurer shall also mean medical service plans, hospital service plans, health maintenance organizations, and prepaid limited health care service plans. For the purposes of this Part, these foregoing entities shall be deemed to be engaged in the business of insurance.

D. "Person" means any natural or artificial entity, including but not limited to individuals, partnerships, associations, trusts, or corporations.

E. "Policy" or "certificate" means any contract of insurance, indemnity, medical, health or hospital service, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any insurer.

F. "Producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance, and includes all persons or business entities otherwise referred to in the Louisiana Insurance code as "insurance agent", "agent", "insurance broker", "broker", "insurance solicitor", "solicitor", or "surplus lines broker".

Acts 1958, No. 125; Acts 1993, No. 953, §1; Acts 1997, No. 949, §1; Acts 2001, No. 158, §1, eff. Jan. 1, 2002.

§1213. Unfair methods and unfair or deceptive acts and practices prohibited

No person shall engage in this state in any trade practice which is defined in this Part to be an unfair method of competition or an unfair or deceptive act or practice in the conduct of the business of insurance, including unauthorized insurance as provided in R.S. 22:1*249 et seq.*

Acts 1958, No. 125; Acts 1993, No. 953, §1.

§1214. Methods, acts, and practices which are defined herein as unfair or deceptive

The following are declared to be unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies. Making, issuing, circulating, or causing to be made, issued, or circulated any estimate, illustration, circular or statement, sales presentation, omission, or comparison that does any of the following:

(a) Misrepresents the benefits, advantages, conditions, or terms of any policy issued or to be issued.

(b) Misrepresents the dividends or share of the surplus to be received on any policy.

(c) Makes a false or misleading statement as to the dividends or share of surplus previously paid on similar policies.

(d) Makes any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates.

(e) Misrepresents to any policyholder insured by any insurer for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance.

(f) Uses any name or title of any policy or class of policies misrepresenting the true nature thereof.

(g) Is a misrepresentation for the purpose of effecting a pledge or assignment or effecting a loan against any policy.

(h) Misrepresents any policy as being shares of stock.

(2) False information and advertising generally. Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

(3) Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(4) Boycott, coercion and intimidation. Entering into any agreement to commit or by any concerted action committing any act of boycott, coercion or intimidation resulting or tending to result in unreasonable restraint of, or a monopoly in, the business of insurance.

(5) False financial statements and false entries.

(a) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of any insurer.

(b) Knowingly making any false entry of a material fact in any book, report, or statement of any insurer or knowingly omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer, or knowingly making any false material statement to any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to which such insurer is required by law to report, or which has authority by law to examine into its condition or into any of its affairs.

(6) Stock operations and advisory board contract. Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any corporation, or securities or any special advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insure.

(7) Unfair discrimination. (a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract, provided that, in determining the class, consideration may be given to the nature of the risk, plan of insurance, the actual or expected expense of conducting the business or any other relevant factor.

(b) Making or permitting any unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, or rates charged for any policy or contract of health or accident insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever, provided that, in determining the class, consideration may be given to the nature of the risk, plan of insurance, the actual or expected expense of conducting the business or any other relevant factor.

(c) Violating the provisions of R.S. 22:652.

(d) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazard by refusing to insure, refusing to renew, cancelling, or limiting the amount of insurance coverage on a property or casualty risk solely because of the geographic location of the risk, unless such action is a result of the application of sound underwriting and actuarial principles related to actual or reasonably anticipated loss experience.

(e) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to insure, refusing to renew, cancelling, or limiting the amount of insurance coverage on the residential property risk, or the personal property contained therein, solely because of the age of the residential property.

(f) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual solely because of the sex, marital status, race, religion, or national origin of the individual. However, nothing in this Subsection shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits. Nothing in this Section shall prohibit or limit the operation of fraternal benefit societies.

(g) Terminating or modifying coverage, or refusing to issue or refusing to renew any property or casualty policy solely because the applicant or insured or employee of either is mentally or physically impaired, unless the applicant, insured, or employee is mentally and physically incapable of operating an automobile and does not possess a valid operator's license issued by the state. However, this Subsection shall not apply to accident health insurance sold by a casualty insurer and shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract.

(h) Refusing to insure solely because another insurer has refused to write a policy, or has cancelled or has refused to renew an existing policy in which that person was the named insured. Nothing herein contained shall prevent the termination of an excess insurance policy on account of the failure of the insured to maintain any required underlying insurance.

(i) With regard to automobile liability insurance, terminating or modifying coverage, or refusing to issue or refusing to renew any policy solely because the applicant or insured filed for bankruptcy. This Subparagraph shall not apply where the refusal to continue to insure is based upon nonpayment of premium.

j. With regards to automobile liability insurance, refusing to issue insurance coverage or increasing insurance premiums solely based upon a lapse in insurance coverage where the insured is serving in the military and has been deployed and has performed military services out of state and where the individual has previously surrendered his automobile license number plate to the office of motor vehicles in compliance with R.S. 47:505(B). This Paragraph shall apply to all existing and new insurance policies as well as renewals of existing policies.

(8) Rebates. Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of insurance including life insurance, life annuity or health and accident insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance or annuity or in connection therewith, any stock, bonds, or other securities of any insurer or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

Nothing in paragraph (7) or this paragraph (8) of this Sub-section shall be construed as including within the definition of discrimination or rebates any of the following practices:

(a) Paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interest of the insurer and its policyholders;

(b) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have paid premiums in advance or continuously for a specified period made premium payment directly to an office of the insurer in an amount which fairly represents the saving in collection expense;

(c) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first year or of any subsequent year of insurance thereunder, which may be made retroactive only for such policy year;

(d) Agents accepting on their own responsibility, notes for the first premiums.

(9) Requiring as a condition precedent to lending money upon the security of a mortgage on movable or immovable property that the borrower negotiate any policy of insurance covering such property through a particular insurance agent or agents, company or companies, type of company or types of companies, broker or brokers. Provided, however, that this provision shall not prevent the exercise by any mortgagee of his right to approve the insurer selected by the borrower on a reasonable non-discriminatory basis related to the solvency of the company and its ability to service the policy. The mortgagee may require that the amount of insurance be at least in an amount to protect the amount of the loan on a type of policy furnishing reasonable protection to the mortgagee in a form selected by the borrower which may include additional coverages not inuring to the benefit of the mortgagee and reasonably associated or connected with the property which is the subject of the loan or mortgage. Notwithstanding the provisions of R.S. 22:1212, any lender either directly or indirectly requiring a borrower to furnish insurance upon such property shall be subject to the conditions and prohibitions of this paragraph.

(10) Tying, which shall mean the following:

(a) The requirement by a health and accident agent or group health and accident insurer, individual health and accident insurer, or health maintenance organization, as a condition to the offer or sale of a health benefit plan to a group or individual insured, that such insured purchase any other insurance policy.

(b) Tying of a purchase of a health and life insurance policy or policies to another insurance product. "Tying" is the requirement by any small employer health insurance carrier or individual health insurance carrier, as a condition to the offer or sale of a health benefit plan, health maintenance organization, or prepaid limited health care service plan to a small employer, as defined by this Code, or to an individual, that such employer or individual purchase any other insurance product.

(c) Tying does not include the joint sale of group life and group health coverages or the joint sale of group life and/or group health and any other employee benefit plan.

(11) No person, as defined in R.S. 22:5(6), shall directly or indirectly participate in any plan to offer or effect any kind or kinds of life or health insurance and annuities as an inducement to or in connection with the purchase by the public of any goods, securities, commodities, services or subscriptions to periodicals. This paragraph shall not apply to such insurance, written in connection with an indebtedness, one of the purposes of which is to pay the indebtedness in case of the death or disability of the debtor. Nor shall this paragraph apply to the sale by life insurance agents, or by life insurance companies of equity products, including equities, mutual funds, shares of investment companies, variable annuities, and including face amount certificates of regulated investment companies under offerings registered with the Federal Securities and Exchange Commission.

(12) Any violation of any prohibitory law of this state.

(13) Fraudulent insurance act. A fraudulent insurance act is one committed by a person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker, or any agent thereof, any written statement as part of, or in support of, or in opposition to an application for the issuance of, or the rating of an insurance policy for commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which he knows to contain materially false information concerning any fact material thereto; or conceal for the purpose of misleading information concerning any fact material thereto.

(14) Unfair claims settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following:

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue.

(b) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(c) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(d) Refusing to pay claims without conducting a reasonable investigation based upon all available information.

(e) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

(f) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(g) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds.

(h) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(i) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured.

(j) Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made.

(k) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(l) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(m) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(n) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(o) Failing to provide forms necessary to present claims within fifteen calendar days of a request with reasonable explanations regarding their use, if the insurer maintains the forms for that purpose.

(15)(a) The issuance, delivery, issuance for delivery, or renewal of, or execution of a contract for, a health benefits policy or plan which:

(i) Prohibits or limits a person who is an insured or other beneficiary of the policy or plan from selecting a pharmacy or pharmacist of the person's choice to be a provider under the policy or plan to furnish pharmaceutical services or pharmaceutical products offered or provided by that policy or plan or in any manner interferes with that person's selection of a pharmacy or pharmacist, provided that the chosen pharmacy or pharmacist agrees in writing to provide pharmaceutical services and pharmaceutical products that meet all the terms and requirements, including the same administrative, financial, and professional conditions and a minimum contract term of one year if requested, that apply to all other pharmacies or pharmacists who have been designated as providers under the policy or plan or as participating providers in a pharmacy network established by the policy or plan.

(ii) Denies a pharmacy or pharmacist the right to participate as a contract provider of pharmaceutical services or pharmaceutical products under the policy or plan, or under a pharmacy network established by the policy or plan, if the pharmacy or pharmacist agrees in writing to provide pharmaceutical services and pharmaceutical products that meet all the terms and requirements, including the same administrative, financial, and professional conditions and a minimum contract term of one year, if requested, which apply to pharmacies and pharmacists which have been designated as providers under the policy or plan or as participating providers in a pharmacy network established by the policy or plan.

(b) This Paragraph shall not, however, require a health benefits policy or plan to provide pharmaceutical services or pharmaceutical products.

(c) As used in this Paragraph, the following terms shall be given these meanings:

(i) "Drug" and "prescription" have the meanings assigned by R.S. 37:1171 and regulations of the Louisiana Board of Pharmacy.

(ii) "Health benefits policy or plan" means any and all health and accident insurance policies or contracts, including but not limited to individual, group, family, family group, blanket, and association health and accident insurance policies, as well as health maintenance organizations and preferred provider organizations, and any and all other third-party payment plans or contracts, and any and all other health care or health benefits plans, policies, contracts, or funds that either in whole or in part provide benefits for pharmaceutical services and pharmaceutical products that are necessary as a result of or to prevent an accident or sickness.

(iii) "Interferes" or "interferes with" means and includes but is not limited to the charging to or imposing on an insured or other beneficiary who does not utilize a specified or designated pharmacy or pharmacist, a copayment fee or other condition not equally charged to or imposed on all insureds or other beneficiaries in or under the same program or policy or plan. However, "interferes" or "interferes with" does not mean or include the advertisement, or periodic dissemination, to all insureds or other beneficiaries of current lists of all pharmacies or pharmacists who have agreed to participate as a contract provider pursuant to the requirements of R.S. 22:1214(15)(a)(ii).

(iv) "Pharmaceutical product" means a "drug" and "prescription", as defined in this Paragraph, and home intravenous therapies.

(v) "Pharmaceutical services" means services that are ordinarily and customarily rendered by a pharmacy or pharmacist, including the preparation and dispensing of pharmaceutical products.

(vi) "Pharmacist" means a person licensed to practice pharmacy under the Pharmacy Law and Board of Pharmacy regulations of the state of Louisiana.

(vii) "Pharmacy" has the meaning assigned by R.S. 37:1171 and regulations of the Louisiana Board of Pharmacy.

(d) This Paragraph shall be cited as the "Patient Pharmacy Preference Act".

(16) Failure to maintain marketing and performance records. Failure of an insurer to maintain its books, records, documents, and other business records in such an order that data regarding complaints, claims, rating, underwriting, and marketing are accessible and retrievable for examination by the insurance commissioner. Data for at least the current calendar year and the two preceding years shall be maintained.

(17) Failure to maintain adequate complaint handling procedures. Failure of any insurer to maintain a complete record of all the complaints that it received since the date of its last examination. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this Paragraph, "complaint" shall mean any written communication primarily expressing a grievance received by the insurer from the Department of Insurance.

(18) Misrepresentation in insurance application. Making false or fraudulent statements or representations on or relative to an application for a policy, for the purpose of obtaining a fee, commission, money, or other benefit from any provider or individual person.

(19) Unfair financial planning practices. An insurance producer:

(a) Holding himself out, directly or indirectly, to the public as a "financial planner", "investment adviser", "consultant", "financial counselor", or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters, or trust and estate matters when such person is in fact engaged only in the sale of policies.

(b)(i) Engaging in the business of financial planning without disclosing to the client prior to the execution of the agreement provided for in Subparagraph (c) or solicitation of the sale of a product or service that:

(aa) He is also an insurance salesperson.

(bb) That a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case.

(ii) The disclosure requirement under this Paragraph may be met by including it in any disclosure required by federal or state securities law.

(c)(i) Charging fees other than commissions for financial planning by insurance producer, unless such fees are based upon a written agreement, signed by the party to be charged in advance of the performance of the services under the agreement. A copy of the agreement shall be provided to the party to be charged at the time the agreement is signed by the party.

(aa) The services for which the fee is to be charged shall be specifically stated in the agreement.

(bb) The amount of the fee to be charged or how it will be determined or calculated shall be specifically stated in the agreement.

(cc) The agreement shall state that the client is under no obligation to purchase any insurance product through the insurance agent, broker, or consultant.

(ii) The insurance producer shall retain a copy of the agreement for not less than three years after completion of services, and a copy shall be available to the commissioner upon request.

(20) Failure to provide claims history.

(a) Loss information - property and casualty. Failure of a company issuing property and casualty insurance to provide the following loss information for the three previous policy years to the first named insured within thirty days of receipt of the first named insured's written request:

(i) On all claims, date, and description of occurrence, and total amount of payments.

(ii) For any occurrence not included in Item (i) of this Paragraph, the date and description of occurrence.

(b) Should the first named insured be requested by a prospective insurer to provide detailed loss information in addition to that required under Subparagraph (a), the first named insured may mail or deliver a written request to the insurer for the additional information. No prospective insurer shall request more detailed loss information than reasonably required to underwrite the same line or class of insurance. The insurer shall provide information under this Subparagraph to the first named insured as soon as possible, but in no event later than twenty days of receipt of the written request. Notwithstanding any other provision of this Section, no insurer shall be required to provide loss reserve information, and no prospective insurer may refuse to insure an applicant solely because the prospective insurer is unable to obtain loss reserve information.

(c) The commissioner may promulgate regulations to exclude the providing of the loss information as outlined in Subparagraph (a) for any line or class of insurance where it can be shown that the information is not needed for that line or class of insurance or where the provision of loss information otherwise is required by law.

(d) Information provided under Subparagraph (b) shall not be subject to discovery by any party other than the insured, the insurer, and the prospective insurer.

(21) The issuance of any line of health insurance in the state by an insurer, self-insurer, or other entity that provides health and accident insurance policies or plans within five years after the entity has ceased writing insurance or issuing plans in the state.

(22) The discrimination against an insured, enrollee, or beneficiary in the issuance, payment of benefits, withholding of coverage, cancellation, or nonrenewal of a policy, contract, plan, or program based upon the results of a prenatal test.

(23) The discrimination against an insured, enrollee, or beneficiary in the issuance, payment of benefits, withholding of coverage, cancellation or nonrenewal of a policy, contract, plan, or program based upon the results of a genetic test or receipt of genetic information. Actions of an insurer or third parties dealing with an insurer taken in the ordinary course of business in connection with the sale, issuance or administration of a life, disability income, or long-term care insurance policy are exempt from the provisions of this Paragraph.

(24) Requiring an agent or broker or offering any incentive for agents or brokers who represent more than one company to limit information provided to consumers on limited benefit plans. Failure to comply with the provisions of this Paragraph shall subject the insurer to a penalty, of not less than two thousand five hundred dollars nor more than five thousand dollars, payable to the agent or broker and shall not be subject to the penalties provided for in R.S. 22:1217.

(25) Requiring an agent or broker or offering any incentive for agents or brokers, who represent more than one insurance company, to limit the number of other insurance companies they may represent. This prohibition shall not apply to captive insurance agents or brokers. Failure to comply with the provisions of this Paragraph shall subject the insurer to a penalty up to ten thousand dollars and shall not be subject to the penalties provided for in R.S. 22:1217.

Acts 1958, No. 125. Amended by Acts 1960, No. 402, §1; Acts 1964, No. 371, §1; Acts 1968, No. 351, §1; Acts 1986, No. 744, §1; Acts 1989, No. 638, §1; Acts 1992, No. 22, §1, eff. May 18, 1992; Acts 1993, No. 139, §1; Acts 1993, No. 663, §2, eff. June 16, 1993; Acts 1993, No. 953, §1; Acts 1995, No. 966, §1; Acts 1997, No. 1418, §1; Acts 1999, No. 748, §1; Acts 2003, No. 129, §1, eff. May 28, 2003; Acts 2004, No. 770, §1.

{{**NOTE:** SEE ACTS 1989, NO. 638, §2.}}

§1214.1. Automobile insurance; unfair trade practice

It shall be an unfair method of competition and unfair or deceptive act or practice for any insurer to establish a contract or agreement with any company to manage, handle, or arrange insurance repair work or to act as an agent for the insurer in any manner, where the company establishes a price which must be satisfied by a repair shop as a condition of doing claims repair work for the insurer, and then retains a percentage of the claim paid by the insurer.

Acts 1992, No. 525, §1; Acts 1993, No. 953, §1.

§1214.2. Automobile insurance; unfair trade practice

It shall be an unfair method of competition and an unfair or deceptive act or practice for any insurer to establish a contract or agreement with any individual or company to manage, handle, subcontract, broker, or arrange insurance repair work for any glass repair or replacement on a motor vehicle.

Acts 1993, No. 385, §1; Acts 1993, No. 585, §1.

§1215. Power of commissioner of insurance

The commissioner of insurance shall have power to examine and investigate into the affairs of every person engaged in the business of insurance, including violations of R.S. 22:1249 et seq., in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by this Part.

Acts 1958, No. 125; Acts 1993, No. 953, §1.

§1216. Notice of hearing

Whenever the commissioner shall have reason to believe that any person has been engaged or is engaging in this state in any unfair trade practice as defined in Title 22 of the Louisiana Revised Statutes, whether or not defined in this Part, the commissioner shall notify such person of his belief and hold a hearing in accordance with the provisions of Part XXIX of Title 22 regarding such matter or matters.

Acts 1958, No. 125; Acts 1993, No. 953, §1.

§1217. Violations, penalties

If, after the hearing, the commissioner shall determine that the person charged has engaged in an unfair method of competition or an unfair or deceptive act or practice, he shall reduce his findings to writing and shall issue and cause to be served upon the person charged with the violation a copy of such findings and an order requiring such person to cease and desist from engaging in such method of competition, act, or practice and order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of one hundred thousand dollars unless the person knew or reasonably should have known he was in violation of this Part, in which case the penalty shall be not more than twenty-five thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of two hundred fifty thousand dollars in any six-month period.

(2) Suspension or revocation of the license of the person if he knew or reasonably should have known he was in violation of this Part.

Acts 1958, No. 125. Amended by Acts 1966, No. 179, §1; Acts 1989, No. 638, §1; Acts 1993, No. 953, §1.

{{**NOTE**: SEE ACTS 1989, NO. 638, §2.}}

§1217.1. Cease and desist order; penalty for violation

Any person who violates a cease and desist order of the commissioner under R.S. 22:1217 and while such order is in effect may after notice and hearing under R.S. 22:1351 and upon order of the commissioner be subject at the discretion of the commissioner to any one or more of the following:

(1) A monetary penalty of not more than twenty-five thousand dollars for each and every act or violation, not to exceed an aggregate of two hundred fifty thousand dollars pursuant to such hearing.

(2) Suspension or revocation of such person's license or certificate of authority.

Acts 1989, No. 638, §1; Acts 1993, No. 953, §1.

{{**NOTE**: SEE ACTS 1989, NO. 638, §2.}}

§1218. Grant of civil immunity

A. In the absence of fraud or bad faith, no person shall be subject to civil liability for libel or slander by virtue of filing reports, without malice, or furnishing other information, without malice, required by this Chapter or required by the commissioner under the authority granted in this Code. No civil cause of action of any nature shall arise against such person for any of the following:

(1) For any information relating to suspected fraudulent insurance acts furnished to or received from law enforcement officials, agents, or employees.

(2) For any information relating to suspected fraudulent insurance acts submitted to or received from other persons subject to the provisions of this Chapter.

(3) For any such information furnished in reports to the insurance commissioner, National Association of Insurance Commissioners (NAIC), or any organization established to detect and prevent fraudulent insurance acts, their agents, employees, or designees.

B. No civil cause of action of any nature or kind shall arise against the commissioner or any employee of the insurance department by virtue of the publication of any report or bulletin related to the official activities of the insurance department.

C. Nothing herein is intended to abrogate or modify in any way or form any statutory privilege or immunity heretofore enjoyed by any person.

Acts 1986, No. 744, §1; Acts 1993, No. 953, §1.

§1219. Report by the commissioner

The commissioner of insurance shall annually submit a report to the Senate and House of Representatives committees on insurance relative to complaints received and actions taken pursuant to the provisions of this Part. Such report shall contain information relative to the number of complaints received, and the disposition of same, the amount collected in penalties, the cost of all related proceedings, and such other information as the commissioner deems pertinent or the insurance committees shall request.

Acts 1989, No. 638, §1; Acts 1992, No. 377, §1, eff. June 17, 1992; Acts 1993, No. 953, §1.

{{**NOTE**: SEE ACTS 1989, NO. 638, §2.}}

§1220. Good faith duty; claims settlement practices; cause of action; penalties

A. An insurer, including but not limited to a foreign line and surplus line insurer, owes to his insured a duty of good faith and fair dealing. The insurer has an affirmative duty to adjust claims fairly and promptly and to make a reasonable effort to settle claims with the insured or the claimant, or both. Any insurer who breaches these duties shall be liable for any damages sustained as a result of the breach.

B. Any one of the following acts, if knowingly committed or performed by an insurer, constitutes a breach of the insurer's duties imposed in Subsection A:

(1) Misrepresenting pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to pay a settlement within thirty days after an agreement is reduced to writing.

(3) Denying coverage or attempting to settle a claim on the basis of an application which the insurer knows was altered without notice to, or knowledge or consent of, the insured.

(4) Misleading a claimant as to the applicable prescriptive period.

(5) Failing to pay the amount of any claim due any person insured by the contract within sixty days after receipt of satisfactory proof of loss from the claimant when such failure is arbitrary, capricious, or without probable cause.

C. In addition to any general or special damages to which a claimant is entitled for breach of the imposed duty, the claimant may be awarded penalties assessed against the insurer in an amount not to exceed two times the damages sustained or five thousand dollars, whichever is greater. Such penalties, if awarded, shall not be used by the insurer in computing either past or prospective loss experience for the purpose of setting rates or making rate filings.

D. The provisions of this Section shall not be applicable to claims made under health and accident insurance policies.

E. REPEALED BY ACTS 1997, No. 949, §2.

F. The Insurance Guaranty Association Fund, as provided in R.S. 22:1375 et seq., shall not be liable for any special damages awarded under the provisions of this Section.

Acts 1990, No. 308, §1, eff. July 6, 1990; Acts 1997, No. 949, §2.

PART XXVI-A. UNAUTHORIZED INSURERS FALSE ADVERTISING PROCESS LAW

§1231. Purpose of Part

The purpose of this Part is to subject certain insurers to the jurisdiction of the commissioner of this state and to the jurisdiction of the courts of this state in connection with fraudulent or false advertising of insurers not authorized to transact business in this state who circulate false or fraudulent advertising therein. In furtherance of such state interest, the legislature herein provides a method of substituted service of process upon such insurers and declares that in so doing, it exercises its power to protect its residents and to define, for the purpose of this statute, what constitutes doing business in this state, and also exercises powers and privileges available to the state by virtue of Public Law 15, 79th Congress of the United States, Chapter 20, 1st Session, S. 340, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states, the authority provided herein to be in addition to any existing powers of this state.

Added by Acts 1966, No. 174, §1.

§1232. Definitions

When used in this Part:

(a) "Commissioner" shall mean the commissioner of insurance of this state.

(b) "Unfair Trade Practice Law" shall mean the Law relating to unfair methods of competition and unfair and deceptive acts and practices in the business of insurance, as set out in Part XXVI of this Title.

(c) "Residents" shall mean and include person, partnership or corporation domestic, alien or foreign.

Added by Acts 1966, No. 174, §1.

§1233. Misrepresentations by foreign insurer, notice to domiciliary supervisory official

No unauthorized foreign or alien insurer of the kind described in R.S. 22:1231 shall make, issue, circulate or cause to be made, issued or circulated, to residents of this state any estimate, illustration, circular, pamphlet, or letter, or cause to be made in any newspaper, magazine or other publication or over any radio or television station, any announcement or statement to such residents misrepresenting its financial condition or the terms of any contracts issued or to be issued or the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon in violation of the Unfair Trade Practice Law, and whenever the commissioner shall have reason to believe that any such insurer is engaging in such unlawful advertising, it shall be his duty to give notice of such fact by registered mail to such insurer and to the insurance supervisory official of the domiciliary state of such insurer. For the purpose of this Section, the domiciliary state of an alien insurer shall be deemed to be the state of entry or the state of the principal office in the United States.

Added by Acts 1966, No. 174, §1.

§1234. Action by commissioner

If after thirty days following the giving of the notice mentioned in R.S. 22:1233 such insurer has failed to cease making, issuing, or circulating such false misrepresentations or causing the same to be made, issued or circulated in this state, and if the commissioner has reason to believe that a proceeding by him in respect to such matters would be to the interest of the public, and that such insurer is issuing or delivering contracts of insurance to residents of this state or collecting premiums on such contracts or doing any of the acts enumerated in R.S. 22:1235, he shall take action against such insurer under the Unfair Trade Practice Law.

Added by Acts 1966, No. 174, §1.

§1235. Service upon unauthorized insurer

A. Any of the following acts in this state, effected by mail or otherwise, by any such unauthorized foreign or alien insurer: (1) the issuance or delivery of contracts or insurance to residents of this state, (2) the solicitation of applications for such contracts, (3) the collection of premiums, membership fees, assessments or other considerations for such contracts, or (4) any other transaction of insurance business, is equivalent to and shall constitute an appointment by such insurer of the secretary of state and his successor or successors in office, to be its true and lawful attorney, upon whom may be served all statements of charges, notices and lawful process in any proceeding instituted in respect to the misrepresentations set forth in R.S. 22:1233 under the provisions of the Unfair Trade Practice Law, or in any action, suit or proceeding for the recovery of any penalty therein provided, and any such act shall be signification of its agreement that such service of statement of charges, notices or process is of the same legal force and validity as personal service of such statement of charges, notices or process in this state, upon such insurer.

B. Service of a statement of charges and notices under said Unfair Trade Practice Law shall be made by any deputy or employee of the commissioner of insurance delivering to and leaving with the secretary of state or some person in apparent charge of his office, two copies thereof. Service of process issued by any court in any action, suit or proceeding to collect any penalty under said Law provided, shall be made by delivering and leaving with the secretary of state or some person in apparent charge of his office, two copies thereof. The secretary of state shall forthwith cause to be mailed by registered mail one of the copies of such statement of charges, notices or process to the defendant at its last known principal place of business, and shall keep a record of all statements of charges, notices and process so served. Such service of statement of charges, notices, or process shall be sufficient provided they shall have been so mailed and the defendant's receipt or receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the person mailing such letter showing a compliance herewith are filed with the commissioner of insurance in the case of any statement of charges or notices, or with the clerk of the court in which such action is pending in the case of any process, on or before the date the defendant is required to appear or within such further time as may be allowed.

C. Service of statement of charges, notices and process in any such proceeding, action or suit shall in addition to the manner provided in Subsection B of this Section be valid if served upon any person within this state who on behalf of such insurer is

(1) Soliciting insurance, or

(2) Making, issuing or delivering any contract of insurance, or

(3) Collecting or receiving in this state any premium for insurance; and a copy of such statement of charges, notices or process is sent within ten days thereafter by registered mail by or on behalf of the commissioner to the defendant at the last known principal place of business of the defendant, and the defendant's receipt, or the receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter, the name and address of the person to whom the letter is addressed, and the affidavit of the person mailing the same showing a compliance herewith, are filed with the commissioner in the case of any statement of charges or notices, or with the clerk of the court in which such action is pending in the case of any process, on or before the date the defendant is required to appear or within such further time as the court may allow.

D. No cease or desist order or judgment by default or a judgment pro confesso under this Section shall be entered until the expiration of thirty days from the date of the filing of the affidavit of compliance.

E. Service of process and notice under the provisions of this Part shall be in addition to all other methods of service provided by law, and nothing in this Part shall limit or prohibit the right to serve any statement of charges, notices or process upon any insurer in any other manner now or hereafter permitted by law.

Added by Acts 1966, No. 174, §1.

PART XXVI-B. INSURANCE FRAUD

§1241. Purpose and powers

A. The purpose of this Part is to create within the Department of Insurance a section of insurance fraud. This section shall be charged with the responsibility, when requested by the commissioner of insurance, to conduct investigations and background criminal checks on all applicants for a license or certificate of authority to transact a business of insurance.

B. In the event the applicant is a corporation, partnership, or other legal entity, the criminal searches shall be limited to those individuals who are directors, officers, employees, or individuals who own or control at least ten percent of the entity. If the section has reason to believe, whether acting on its own initiative or as a result of complaints, that a person has engaged in, or is engaging in, an act or practice that violates this Part or any other provision of the Insurance Code, it may examine and investigate into the affairs of such person and may administer oaths and affirmations, serve subpoenas ordering the attendance of witnesses, and collect evidence.

C. If during the course of investigation, the Department of Insurance determines that there may be a violation of any criminal law, the investigation shall then be turned over to the Louisiana Department of Justice, the Department of Public Safety and Corrections, public safety services, office of state police, and other appropriate law enforcement and/or prosecutorial agency, for further investigation, enforcement, or prosecution.

Acts 1992, No. 707, §2; Acts 1994, 3rd Ex. Sess., No. 50, §2; Acts 1999, Np. 1312, §1; Acts 2004, No. 826, §1.

§1241.1. Additional powers and duties

A. The Department of Insurance, section of insurance fraud, is authorized to have direct access to information compiled by the Federal Bureau of Investigation, as contained in the National Crime Identification Center for the purposes of licensure or the granting, denying, revocation, suspension or any other action on an application for a license or certificate of authority to be an insurer in the state, subject to the approval of the office of state police.

B. The Department of Insurance, section of insurance fraud, is authorized to require all applicants for a license or certificate of authority to submit physical evidence of the identity of the applicant. The commissioner of insurance is authorized to promulgate rules and regulations defining the type of physical identification acceptable and the manner in which such evidence is to be received by the Department of Insurance.

C. The commissioner of insurance may deny a license or certificate of authority when the applicant, or if the applicant is a corporation, partnership, limited liability company or partnership, or other legal entity, any officer, director, managing person, employee, or principal stockholder has been convicted of a felony.

Acts 1994, 3rd Ex. Sess., No. 50, §2; Acts 2004, No. 826, §1.

§1242. Definitions

As used in this Part the following terms shall have the meanings indicated herein:

(1) "Fraudulent insurance act" shall include but not be limited to acts or omissions committed by any person who, knowingly and with intent to defraud:

(a) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, reinsurer, purported insurer or reinsurer, broker, or any agent thereof, any oral or written statement which he knows to contain materially false information as part of, or in support of, or denial of, or concerning any fact material to or conceals any information concerning any fact material to the following:

(i) An application for the issuance of any insurance policy.

(ii) The rating of any insurance policy.

(iii) A claim for payment or benefit pursuant to any insurance policy.

(iv) Premiums paid on any insurance policy.

(v) Payments made in accordance with the terms of any insurance policy.

(vi) An application for certificate of authority or the application for a certificate of authority by a health insurer that has ceased writing health and accident insurance in the state within the prior five years.

(vii) The financial condition of any insurer, reinsurer, purported insurer or reinsurer.

(viii) The acquisition of any insurer or reinsurer.

(b) Solicits or accepts new or renewal insurance risks by or for an insolvent insurer, reinsurer, or other entity regulated under the insurance laws of this state.

(c) Removes or attempts to remove the assets or record of assets, transactions, and affairs of such material part thereof, from the home office or other place of business of the insurer, reinsurer, or other entity regulated under the insurance laws of this state, or from the place of safekeeping of the insurer, reinsurer, or other entity regulated under the laws of this state, or who conceals or attempts to conceal the same from the department.

(d) Diverts, attempts to divert, or conspires to divert funds of an insurer, reinsurer, or other entity regulated under the laws of this state, or other persons in connection with:

(i) The transaction of insurance or reinsurance.

(ii) The conduct of business activities by an insurer, reinsurer, or other entity regulated by the insurance laws of this state.

(iii) The formation, acquisition, or dissolution of an insurer, reinsurer, or other entity regulated under the insurance laws of this state.

(e) Supplies false or fraudulent material information pertaining to any document or statement required by the Department of Insurance.

(f) Commits any fraudulent viatical settlement act, as defined by R.S. 22:191.

(g) Solicits or accepts new or renewal insurance risks by or for an unauthorized insurer, except as provided by Part XXVII of this Chapter.

(2) "Statement" includes but is not limited to any notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, test results, x-rays, or other evidence of loss, injury, or expense.

Acts 1992, No. 707, §2; Acts 1993, No. 663, §2, eff. June 16, 1993; Acts 2004, No. 498, §1.

§1243. Prohibited activities and sanctions

A. Any person who, with the intent to injure, defraud, or deceive any insurance company, or the Department of Insurance, or any insured or other party in interest, or any third party claimant:

(1) Commits any fraudulent insurance act as defined in R.S. 22:1242;

(2) Presents or causes to be presented any written or oral statement including computer-generated documents as part of or in support of or denial of a claim for payment or other benefit pursuant to an insurance policy, knowing that such statement contains any false, incomplete, or fraudulent information concerning any fact or thing material to such claim;

(3) Assists, abets, solicits, or conspires with another to prepare or make any written or oral statement that is intended to be presented to any insurance company, insured, or other party in interest or third party claimant in connection with, or in support of or denial, or any claim for payment of other benefit pursuant to an insurance policy, knowing that such statement contains any false, incomplete, or fraudulent information concerning any fact or thing material to such claim;

is guilty of a felony and shall be subjected to a term of imprisonment, with or without hard labor, not to exceed five years, or a fine not to exceed five thousand dollars, or both, on each count.

B. The criminal provisions of this Section shall be investigated, enforced, or prosecuted only by the proper law enforcement and prosecutorial agencies.

Acts 1992, No. 707, §2; Acts 2001, No. 1158, §1.

§1244. Automobile insurance policies

A. Any person who with an intent to injure, defraud, or deceive any insurance company:

(1) Knowingly causes or participates in a vehicular collision, or any other vehicular accident, for the purpose of presenting any false or fraudulent claim;

(2) Knowingly presents or causes to be presented multiple claims for the same loss or injury, including presentation of multiple claims to more than one insurer, with an intent to defraud; or

(3) Engages in any of the actions or activities described in R.S. 22:1243, relative to insurance policies in general; is guilty of a felony and shall be subjected to a term of imprisonment, with or without hard labor, not to exceed five years or a fine not to exceed five thousand dollars, or both, and payment of restitution to the victim company of any insurance payments to the defendant that the court determines was not owed and the costs incurred by the victim company associated with the evaluation and defense of the fraudulent claim, including but not limited to the investigative costs, attorney fees, and court costs.

B. The criminal provisions of this Section shall be investigated, enforced, or prosecuted only by the proper law enforcement and prosecutorial agencies.

C. The provisions of this Section shall not extinguish any civil cause of action in favor of the victim company, but shall reduce any civil judgment by any restitution actually received by the company under this Section.

Acts 1992, No. 707, §2; Acts 2005, No. 450, §1.

§1245. Duties of companies and others

A. Any person, company, or other legal entity including but not limited to those engaged in the business of insurance, including agents, brokers, and adjusters, which believes that a fraudulent claim is being made, shall within sixty days of the receipt of such notice, send to the section of insurance fraud, on a form prescribed by the section, the information requested and such additional information relative to the claim and the parties claiming loss or damages because of an occurrence or accident as the section may require. The section of insurance fraud shall review such reports and select such claims as, in its judgment, may require further investigation. It shall then cause an independent examination of the facts surrounding such claim to be made to determine the extent, if any, to which fraud, deceit, or intentional misrepresentation of any kind exists in the submission of the claim.

B. The section of insurance fraud shall report any alleged violations of law which its investigations disclose to the appropriate licensing agency, the insurance fraud investigation unit of the office of state police, the insurance fraud support unit of the Department of Justice, and the prosecutive authority having jurisdiction with respect to any such violation. These units shall work jointly on criminal referrals.

Acts 1992, No. 707, §2; Acts 1999, No. 1312, §2, eff. Jan. 1, 2000; Acts 2001, No. 598, §1.

§1246. Materials and evidence

A. If matter that the section seeks to obtain by request is located outside the state, the person so requested may make it available to the section or its representative to examine at the place where it is located. The section may designate representatives, including officials of the state in which the matter is located, to inspect the matter on its behalf, and it may respond to similar requests from officials of other states.

B. The section's papers, documents, reports, or evidence relative to the subject of an investigation under this Part shall not be subject to public inspection for so long as the section deems reasonably necessary to complete the investigation, to protect the person investigated from unwarranted injury, or to be in the public.* Further, such papers, documents, reports, or evidence relative to the subject of investigation under this Section shall not be subject to subpoena until opened for public inspection by the section, unless the section consents, or until after notice to the section and a hearing, a court of competent jurisdiction determines the section would not be necessarily hindered by such subpoena. Section investigators shall not be subject to subpoena in civil actions by any court of this state to testify concerning any matter of which they have knowledge pursuant to a pending insurance fraud investigation by the section.

Acts 1992, No. 707, §2.

*As appears in enrolled bill.

§1247. Civil immunity

A. No insurer, employees, or agents of any insurer, or any other person acting without malice, fraudulent intent, or bad faith, shall be subject to civil liability for libel, slander, or any other relevant tort, and no civil cause of action of any nature shall exist against such person or entity by virtue of the filing of reports or furnishing other information, either orally or in writing, concerning suspected, anticipated, or completed fraudulent insurance acts when such reports or information are required by this Part or required by the section of insurance fraud as a result of the authority herein granted or when such reports or information are provided to or received from:

(1) Law enforcement officials, their agents, and employees.

(2) The National Association of Insurance Commissioners, the state Department of Insurance, a federal or state agency or bureau established to detect and prevent fraudulent insurance acts, as well as any other organization established for the same purpose, their agents, employees, or designees.

(3) A person involved in the prevention and detection of fraudulent insurance acts or that person's employees, agents, or representatives.

B. This Section does not abrogate or modify in any way any statutory or other privilege or immunity heretofore enjoyed by such person or entity.

C. Any person or entity covered by the provisions of this Section shall be entitled to an award of attorney fees and costs if they are the prevailing party in a civil suit and the party bringing the action was not substantially justified in doing so. For the purposes of this Section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

Acts 1992, No. 707, §2; Acts 2001, No. 1158, §2.

§1247.1. Confidentiality of criminal background checks, civil penalties

A. Notwithstanding any other provision of law to the contrary, criminal background information in the possession of the fraud section of the Department of Insurance shall be confidential and shall not be disclosed to others outside of the fraud section except as necessary for action on the application of the applicant.

B. Disclosure of information in violation of Subsection A of this Section shall result in a fine of five hundred dollars for the first disclosure and one thousand dollars for each subsequent disclosure by the same individual.

Acts 1994, 3rd Ex. Sess., No. 50, §2.

PART XXVII. UNAUTHORIZED INSURANCE

§1248. Purpose; necessity for regulation

This Part shall be liberally construed and applied to promote its underlying purposes which include:

(1) Protecting persons seeking insurance in this state.

(2) Permitting surplus lines insurance to be placed with reputable and financially sound unauthorized insurers under the provisions of this Part.

(3) Establishing a system of regulation which will permit orderly access to surplus lines insurance in this state and encourage authorized insurers to provide new and innovative types of insurance available to consumers in this state.

(4) Providing a system through which persons may purchase insurance other than surplus lines insurance, from unauthorized insurers pursuant to this Part.

(5) Protecting revenues of this state.

(6) Providing a system pursuant to this Part which subjects unauthorized insurance activities in this state to the jurisdiction of the insurance commissioner and state and federal courts in suits by or on behalf of the state.

Acts 1997, No. 1340, §1, eff. July 15, 1997.

§1249. Transacting a business of insurance by unauthorized insurer defined

A. Any of the following acts in this state, effected by mail or otherwise, by an unauthorized insurer or by any person acting with actual or apparent authority of the insurer, on behalf of the insurer, is deemed to constitute the transaction of an insurance business in or from this state:

(1) The making of or proposing to make, as an insurer, an insurance contract.

(2) The solicitation, taking or receiving of any application for insurance contract.

(3) The receiving or collection of any premiums, commissions, membership fees, assessment, dues, or other considerations for any insurance contract or any part thereof.

(4) The issuance or delivery of contracts of insurance to residents of this state or to corporations or persons authorized to do business in this state.

(5) The transaction of any matter subsequent to the execution of such a contract and arising out of it.

(6) The doing or proposing to do any insurance business in substance equivalent to any of the foregoing in a manner designed to evade the provisions of the insurance laws of this state.

(7) The solicitation, negotiation, procurement, or effectuation of insurance or renewals thereof.

(8) The transaction of any kind of insurance business specifically recognized as transacting business within the meaning of the statutes relating to insurance.

(9) The dissemination of information as to coverage or rates, or forwarding application(s), or delivery of policies or contracts, or inspection of risks, the fixing of rates or investigation or adjustment of claims or losses or the transaction of matters subsequent to effectuation of the contract and arising out of it, or any other manner of representing or assisting a person or insurer in the transaction of risks with respect to properties, risks, or exposures located or to be performed in this state.

(10) The making or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety.

(11) The offering of insurance or the transacting of insurance business, or the offering of an agreement or contract which purports to alter, amend, or void coverage of an insurance contract.

B. The venue of an act committed by mail shall be at the point where the matter transmitted by mail is delivered or issued for delivery or takes effect.

Added by Acts 1968, No. 52, §1; Acts 1990, No. 885, §1; Acts 1993, No. 663, §2, eff. June 16, 1993; Acts 1997, No. 1340, §1, eff. July 15, 1997.

§1249.1. Placement of insurance business; prohibitions and exclusions

A. An insurer shall not engage in the transaction of insurance unless authorized by a certificate of authority or otherwise is qualified pursuant to the laws of this state, or exempted by this Part or otherwise exempted by the insurance laws of this state.

B. A person shall not engage in a transaction of insurance nor shall in this state, directly or indirectly, act as agent for, or otherwise represent or aid on behalf of another, an unauthorized insurer in the solicitation, negotiation, procurement, or effectuation of insurance, or renewals thereof, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, or fixing of rates, or investigation or adjustment of claims or losses, or collection or forwarding of premiums, or in any other manner represent or assist the insurer in the transaction of insurance.

C. This Section shall not apply to a person acting in this state in the placement of the following types of insurance:

(1) The lawful transaction of surplus lines insurance as provided in this Title.

(2) Reinsurance provided that such reinsurer meets the following requirements, unless waived by the commissioner:

(a) The assuming insurer is authorized to operate an insurance or reinsurance business by its domiciliary jurisdiction and is authorized to write the type of reinsurance in its domiciliary jurisdiction.

(b) The assuming insurer satisfies all legal requirements for such reinsurance in the state of domicile of the ceding insurer.

(3) Any life insurance company or annuity company organized and operated without profit to any private shareholder or individual, exclusively for the purpose of aiding educational or scientific institutions organized and operated without profit to any private shareholder or individual by issuing insurance and annuity contracts direct from the home office of the company and without agents or representatives in this state only to or for the benefit of such institutions, and to individuals engaged in the services of such institutions.

(4) Insurance on the property and operation of railroads or aircraft engaged in interstate or foreign commerce, insurance on vessels, crafts, hulls, cargoes, marine builders' risks, marine protection and indemnity, or other risks, including strikes and war risks commonly insured under ocean or wet marine forms or policy. Notwithstanding the exemption provided in this Paragraph, the coverage for any wet marine risk arising out of the exploration, discovery, development, or production for any mineral, the maintenance, shutting in, or the plugging and abandoning of any oil or natural gas or other marine mine shall only be placed by a person that has satisfied all applicable licensing requirements, if any, of this Title and is insured by either an insurer or insurers which appear on the list of insurers pursuant to the provisions of R.S. 22:1262.1 or other insurers which have been affirmatively approved in writing by the commissioner and that satisfy the requirements of R.S. 22:1262. In no circumstance shall the exemption in this Paragraph apply to insurance on vessels and craft under five tons gross weight.

(5) Transactions in this state involving a policy lawfully solicited, written, and delivered outside of this state, covering subjects of insurance not resident located, or expressly to be performed in this state at the time of issue, and which transactions are subsequent to the issuance of the policy.

(6) Transactions involving risks located in this state where the policy or contract of insurance for such risk was principally negotiated and delivered outside this state, and was lawfully issued in a state or foreign country in which the foreign or alien insurer was authorized to operate an insurance business, and where such insurer has no contact with this state except in connection with inspections or losses required by virtue of the contract or policy of insurance covering the risk located in this state, including transactions involving the operation of workers' compensation claims offices pursuant to R.S. 23:1161.1.

Acts 1997, No. 1340, §1, eff. July 15, 1997.

§1250. Insurance commissioner may institute legal proceedings against unauthorized insurer

Whenever the commissioner of insurance believes, from evidence satisfactory to him, that any person or insurer is violating or about to violate any provision of this Part or any order or requirement of the commissioner issued or promulgated pursuant to authority granted the commissioner by any provision of this Code or by law, he may bring an action in the name of the people of the State of Louisiana in the District Court for the Nineteenth Judicial District, Baton Rouge, Louisiana, against such person or insurer to enjoin such person or insurer from continuing such violation or engaging therein or doing any act in furtherance thereof. In such action an order or judgment may be entered awarding such preliminary or final injunction as is proper.

Added by Acts 1968, No. 53, §1.

§1251. Domestic insurer prohibited from issuing policies in state where unauthorized; commissioner's approval required

A. Subject to the exceptions set forth in Subsection C of this Section, no domestic insurer shall enter into a contract of insurance upon the life or person of a resident of another state, or covering property or risks located in another state, unless such insurer is authorized pursuant to the laws of such other state to do business therein.

B. Subject to the exceptions set forth in Subsection C of this Section, no domestic insurer shall offer or issue policies in another state until after the commissioner has granted his approval of the proposed issuance of policies in the other state. In determining whether such approval shall be granted to the insurer, the commissioner shall consider and evaluate the potential impact of such issuance to the interests of the Louisiana policyholders of the domestic insurer.

C. The following constitute the exceptions to the foregoing provisions of this Section:

(1) Contracts entered into where the prospective insurant is personally present in a state in which the insurer is authorized to do business when he signs the application.

(2) Issuance of certificates under any lawfully transacted group life, group accident, group health, or other group disability policy, where the master policy is entered into in a state in which the insurer is authorized to do business.

(3) Contracts made pursuant to a pension or retirement plan of an employer, when such contracts are applied for in a state where the employer is personally present or doing business and the insurer is authorized to do business.

(4) The renewal, reinstatement, conversion, or continuance in force with or without modification of contracts otherwise lawfully entered into and which were not originally executed in violation of this Section.

Acts 1958, No. 125. Amended by Acts 1960, No. 144, §1; Acts 1989, No. 449, §1, eff. Sept. 1, 1989.

§1252. Acting as agent for unauthorized insurer prohibited

A. No person shall act in this state as agent for any insurer not authorized to do business in this state. No person shall negotiate for or place or aid in placing insurance coverage or aid in effecting insurance or in transacting an insurance business either by fixing rates, adjusting or investigating losses, inspecting or examining risks, acting as attorney-in-fact or attorney for service of process or otherwise for any insurer not authorized to do business in this state, nor shall any person so act as an agent for another who is an applicant for insurance covering any property or risk in another state, territory, or district of the United States with any insurer not authorized to transact business in such state, territory, or district, wherein the property or risk is located.

B. The provisions of this Section do not apply to contracts of reinsurance, nor do they apply to an insurer not authorized in this state or its representatives in investigating and adjusting losses or otherwise complying in this state with the terms of its insurance contracts made in a state wherein the insurer was authorized and in which the property or risk was located or residing at the time of the execution of the contract. Furthermore, the provisions of this Section do not apply to agents representing any unauthorized insurer solely for the purpose of operating a worker's compensation claims office pursuant to R.S. 23:1161.1.

Acts 1990, No. 885, §1.

§1253. Transacting business; constitutes appointment of agent for service of process; workers' compensation claims agent

A. The transacting of business in this state by a foreign or alien insurer without a certificate of authority is equivalent to an appointment by such insurer of the Secretary of State and his successor or successors in office to be its true and lawful attorney, upon whom may be served all lawful process in any action, suit or proceeding maintained by the commissioner of insurance or arising out of such policy or contract of insurance, and the said transacting of business by such insurer is a signification of its agreement that any such service of process is of the same legal force and validity as personal service of process in this state upon it.

B. Such service of process shall be made by delivering and leaving with the secretary of state or with some person in apparent charge of his office two copies thereof and the payment to him of such fees as may be prescribed by law. The secretary of state shall forthwith mail by registered mail or by commercial courier as defined in R.S. 13:3204(D), when the person to be served is located outside of this state one of the copies of such process to the defendant at its last known principal place of business, and shall keep a record of all process so served upon him. Such service of process is sufficient, provided notice of such service and a copy of the process are sent within ten days thereafter by registered mail or by commercial courier as defined in R.S. 13:3204(D), when the person to be served is located outside of this state by plaintiff's attorney to the defendant at its last known principal place of business, and the defendant's receipt, or receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff's attorney showing a compliance herewith are filed with the clerk of the court in which such action is pending on or before the date the defendant is required to appear, or within such further time as the court may allow. However, no plaintiff or complainant shall be entitled to a judgment by default, or a judgment with leave to prove damages, or a judgment pro confesso under this Section until the expiration of thirty days from date of the filing of the affidavit of compliance.

C. Service of process in any such action, suit, or proceeding shall, in addition to the manner provided in Subsection B of this Section, be valid if served upon any person within this state who, in this state on behalf of such insurer, is:

(1) Soliciting insurance, or

(2) Making any contract, of insurance or issuing or delivering any policies or written contracts of insurance, or

(3) Collecting or receiving any premium for insurance; and a copy of such process is sent within ten days thereafter by registered mail by the plaintiff's attorney to the defendant at the last known principal place of business of the defendant, and the defendant's receipt, or the receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff's attorney showing a compliance herewith are filed with the clerk of the court in which such action is pending on or before the date the defendant is required to appear, or within such further time as the court may allow.

(4) Acting as an agent for the sole purpose of operating a worker's compensation claims office established pursuant to R.S. 23:1161.1.

D. Nothing in this Section contained shall limit or abridge the right to serve any process, notice or demand upon any insurer in any other manner now or hereafter permitted by law.

Acts 1958, No. 125. Amended by Acts 1968, No. 54, §1; Acts 1990, No. 885, §1; Acts 1999, No. 395, §4.

§1254. Use of courts; prohibited to unauthorized insurer

No unauthorized insurer shall institute or file, or cause to be instituted or filed, any suit, action, or proceeding in this state to enforce any right, claim, or demand arising out of the transaction of business in this state until such insurer shall have either been placed by the Department of Insurance on the list of approved unauthorized insurers, or obtained a certificate of authority to transact insurance business in this state. Nothing in this Section shall be construed to require an unauthorized insurer to obtain a certificate of authority before instituting or filing or causing to be instituted or filed any suit, action, or proceeding either in connection with any of its investments in this state or in connection with any contract issued by it at a time when it was authorized to do business in the state where such contract was issued.

Acts 1958, No. 125; Acts 2003, No. 994, §1, eff. July 2, 2003.

§1255. Requirements to be met before using courts

A. Before any unauthorized insurer shall file or cause to be filed any pleading in any action, suit, or proceeding instituted against it, such unauthorized insurer shall either (1) file with the clerk of the court in which such action, suit, or proceeding is pending a bond with good and sufficient sureties, to be approved by the court, in an amount to be fixed by the court sufficient to secure the payment of any final judgment which may be rendered in such action; or (2) procure a certificate of authority to transact the business of insurance in this state. An insurer that has been placed by the Department of Insurance on the list of approved unauthorized insurers, and which maintains an A.M. Best rating of B or better or its equivalent, is exempt from the requirements of this Subsection. The commissioner shall determine the equivalent standard for insurers rated by recognized rating organizations other than A.M. Best.

B. The court in any action, suit or proceeding in which service is made in the manner provided in Sub-sections B or C of R.S. 22:1253 may order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of Sub-section A of this Section and to defend such action.

C. Nothing in Sub-section A of this Section is to be construed to prevent an unauthorized insurer from filing a motion to quash a writ or to set aside service thereof made in the manner provided in Sub-sections B or C of R.S. 22:1253 on the ground either (1) that no policy or contract of insurance has been issued or delivered to a citizen or resident of this state or to a corporation authorized to do business therein, or (2) that such insurer has not been transacting business in this state, or (3) that the person on whom service was made pursuant to Sub-section C of R.S. 22:1253 was not doing any of the acts therein enumerated.

Acts 1958, No. 125; Acts 2003, No. 994, §1, eff. July 2, 2003.

§1256. Validity of contracts illegally effectuated

A contract of insurance effectuated by an unauthorized insurer in violation of the provisions of this Code shall be voidable except at the instance of the insurer.

Acts 1958, No. 125.

§1257. Surplus line insurance from unauthorized insurers

If certain insurance coverages cannot be procured from authorized insurers, such coverages, hereinafter designated as "surplus lines," may be procured from approved unauthorized insurers provided that the insurance is procured through a licensed surplus line broker.

Acts 1988, No. 191, §1, eff. July 1, 1988; Acts 2004, No. 466, §1, eff. January 1, 2005.

§1258. Endorsement of contract

A. Every insurance contract procured and delivered as a surplus line coverage pursuant to this Part shall have stamped or printed upon it and be signed by the surplus lines broker who procured it, in bold type and the face of which shall not be less than ten-point type, the following:

NOTICE

This insurance policy is delivered as a surplus line coverage under the Insurance Code of the State of Louisiana.

In the event of insolvency of the company issuing this contract, the policyholder or claimant is not covered by the Louisiana Insurance Guaranty Association which guarantees only specific policies issued by an insurance company authorized to do business in Louisiana.

This surplus lines policy has been procured by the following licensed Louisiana surplus lines broker:

_____

Signature of Licensed Louisiana Surplus Lines Broker or Authorized Representative

_____

Printed Name of Licensed Louisiana Surplus Lines Broker

B. The notice required under this Section shall, whether stamped or printed, be distinguished in either one of the following ways:

(1) The notice shall be prominently displayed in the color red.

(2) If the notice is printed or stamped in the color black, it shall be prominently offset by a black border.

Acts 1958, No. 125. Amended by Acts 1958, No. 291, §1; Acts 1972, No. 241, §1; Acts 1999, No. 868, §1; Acts 2004, No. 466, §1, eff. January 1, 2005.

§1259. Surplus line insurance valid

Insurance contracts procured as surplus line coverage from approved unauthorized insurers in accordance with this Part shall be fully valid and enforceable as to all parties, and shall be given recognition in all matters and respects to the same effect as like contracts issued by authorized insurers.

Acts 1958, No. 125; Acts 2004, No. 466, §1, eff. January 1, 2005.

§1260. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1260.1. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1261. REPEALED BY ACTS 1993, NO. 952, §5, EFF. JAN. 1, 1994.
§1262. Surplus lines in solvent insurers; capital and surplus requirements; deposits and bond requirements

A.(1) A surplus lines broker shall not knowingly place surplus lines insurance with insurers unsound financially.

(2) Each insurer is authorized to write the type of insurance in its domiciliary jurisdiction.

(3) The full amount or type of insurance cannot be obtained from insurers who are authorized to do business in this state. In addition to the other requirements of this Part, including but not limited to R.S. 22:1257 and 1263.1, the full amount or type of insurance may be procured from an approved unauthorized insurer, provided that a diligent search is made among the insurers who are authorized to transact business and are actually writing the particular type of insurance in this state if any are writing it.

B. The surplus lines broker shall not so insure with any insurer unless the insurer has met the requirements of R.S. 22:1262.1, unless otherwise provided by law, has established satisfactory evidence of good repute and financial integrity, and has done the following:

(1) If it is a foreign insurer:

(a) Has capital and surplus of not less than fifteen million dollars exclusive of either surplus debentures or subordinated notes if a stock insurer, or surplus of not less than fifteen million dollars exclusive of either surplus debentures or subordinated notes if any other type insurer, and has on deposit with the commissioner of insurance a safekeeping or trust receipt from a bank or a savings and loan association doing business within Louisiana, indicating that one hundred thousand dollars in money, or approved bonds of the United States government, the state of Louisiana or any political subdivision thereof, or in lieu of such deposit has delivered to the commissioner of insurance a bond in the amount of one hundred thousand dollars of an authorized surety company doing business in this state and approved by the commissioner of insurance.

(b) Such deposit or surety bond shall be conditioned for the prompt payment of all claims arising and accruing to any person by virtue of any policy issued by any such unauthorized insurer upon the life or person of any citizen of the state of Louisiana, or upon any property or other risk situated in this state, and to be held subject to any claims, liens or judgments that may be judicially obtained against any such company in the courts of this state, or arising from any contract of insurance, or indemnity, or fidelity, or guaranty entered into in this state, and shall be liable to seizure and sale at the instance of any judgment creditor of such insurer, under judgment obtained in any of the courts of this state or in any of the federal courts of this state.

(c) No surety bond furnished as provided herein shall be cancelled unless a new bond or deposit has been substituted or satisfactory evidence has been submitted to the commissioner of insurance that the insurer has discharged all of its assured obligations and liabilities in this state, and that it has no assessed liabilities whatever remaining in this state. The term of these bonds shall be for one year ending March 1st, but the last bond filed shall always remain in effect until a new bond is filed or a deposit is made as a substitution therefor. Withdrawal of any bond or deposit required herein may be made only upon the approval by the commissioner of insurance.

(d) The requirements of Subparagraph (a) of this Paragraph, with respect only to capital and surplus, may be satisfied by an insurer's possessing less than the minimum capital and surplus upon an affirmative finding by the commissioner. If the commissioner finds such acceptable, the finding shall be in effect for a one-year period and shall be applied for annually thereafter to be renewed on an annual basis, unless the finding is revoked by the commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability, and company record and reputation within the industry. In no event shall the commissioner make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than four million five hundred thousand dollars.

(e) In the case of an insurance exchange created by the laws of a state other than this state:

(i) The syndicates of the exchange shall maintain under terms acceptable to the commissioner capital and surplus, or its equivalent under the laws of its domiciliary jurisdiction, of not less than seventy-five million dollars in the aggregate.

(ii) The exchange shall maintain under terms acceptable to the commissioner not less than fifty percent of the policyholder surplus of each syndicate in a custodial account accessible to the exchange or its domiciliary commissioner in the event of insolvency or impairment of the individual syndicate.

(iii) In addition, each individual syndicate to be eligible to accept surplus lines insurance placements from this state shall meet either of the following requirements: For insurance exchanges which maintain funds in an amount of not less than fifteen million dollars for the protection of all exchange policyholders, the syndicate shall maintain under terms acceptable to the commissioner minimum capital and surplus, or its equivalent under the laws of the domiciliary jurisdiction, of not less than five million dollars; or for insurance exchanges which do not maintain funds in an amount of not less than fifteen million dollars for the protection of all exchange policyholders, the syndicate shall maintain under terms acceptable to the commissioner minimum capital and surplus, or its equivalent under the laws of its domiciliary jurisdiction, of not less than the minimum capital and surplus requirements under the laws of its domiciliary jurisdiction or fifteen million dollars, whichever is greater.

(2) If it is an alien Lloyd's plan or other similar group of insurers, which consists of unincorporated individual insurers, or a combination of both unincorporated and incorporated insurers:

(a) The plan or group maintains in the United States a trust or trusts equal to thirty percent of the group's United States surplus lines gross liabilities excluding those types of insurance liabilities set forth in R.S. 22:1249.1(C)(4), not to exceed five hundred million dollars; however, after notice and an opportunity to be heard, the commissioner may require that the trust or trusts equal an amount in excess of five hundred million dollars if he finds such higher amount to be reasonably necessary to protect the interests of the public and policyholders of this state.

(b) In addition, the group shall maintain in trust a surplus in the amount of one hundred million dollars, which shall be available for the benefit of United States surplus lines policyholders of any member of the group.

(c) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members.

(d) The trust funds shall be maintained in an irrevocable trust account in the United States in a qualified financial institution, consisting of cash, securities, letters of credit, or investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of authorized insurers to write like kinds of insurance in this state and, in addition, the trust required by Subparagraph (b) of this Paragraph shall satisfy the requirements of the standard trust agreement required for listing with the International Insurers Department of the National Association of Insurance Commissioners.

(3) In the case of a group of incorporated alien insurers under common administration, which has continuously transacted an insurance business outside the United States for at least three years immediately prior to December 31, 1997, and which submits to this state's authority to examine its books and records and bears the expense of the examination:

(a) The group shall maintain an aggregate policyholders' surplus of ten billion dollars.

(b) The group shall maintain in trust a surplus in the amount of one hundred million dollars. The surplus shall be available for the benefit of United States surplus lines policyholders of any member of the group.

(c) Each insurer shall individually maintain capital and surplus of not less than twenty-five million dollars per company.

(d) The trust funds shall satisfy the requirements of the Standard Trust Agreement requirement for listing with the International Insurers Department of the National Association of Insurance Commissioners and shall be maintained in an irrevocable trust account in the United States in a qualified financial institution, and shall consist of cash, securities, letters of credit, or investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state.

(e) Additionally, each member of the group shall make available to the commissioner an annual certification of the solvency of the member by the domiciliary regulator of the member and its independent public accountant.

(4) Except for an exchange or plan complying with Subparagraph B(1)(e) or Paragraph B(2) or B(3) of this Section, an alien insurer shall satisfy the capital and surplus requirements of Subparagraphs B(1)(a) through (d) of this Section and shall have in force a trust fund of not less than the greater of:

(a) Five million four hundred thousand dollars.

(b) Thirty percent of the United States surplus lines gross liabilities, which does not include those types of insurance liabilities set forth in R.S. 22:1249.1(C)(4), not to exceed sixty million dollars, to be determined annually on the basis of accounting practices and procedures substantially equivalent to those promulgated by this state, as of December thirty-first next preceding the date of determination, where:

(i) The liabilities are maintained in an irrevocable trust account in the United States in a qualified financial institution, on behalf of United States policyholders consisting of cash, securities, letters of credit, or other investments of substantially the same character and quality as those which are eligible investments pursuant to R.S. 22:844 et seq. for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state. The trust fund, which shall be included in any calculation of capital and surplus or its equivalent, shall satisfy the requirements of the Standard Trust Agreement required for listing with the International Insurers Department of the National Association of Insurance Commissioners.

(ii) The insurer may request approval from the commissioner to use the trust fund to pay valid surplus lines claims. The balance of the trust fund shall never be less than the greater of five million four hundred thousand dollars or thirty percent of the current gross United States surplus lines liabilities of the insurer, excluding those types of liabilities set forth in R.S. 22:1249.1(C)(4).

(iii) In calculating the trust fund amount required by this Paragraph, credit shall be given for surplus lines deposits separately required and maintained for a particular state or United States territory, not to exceed the amount of the loss and loss adjustment reserves of the insurer in the particular state or territory.

(5) An alien insurer subject to the provisions of Paragraph (4) of this Subsection that meets the requirements to do a surplus lines business in this state on July 15, 1997, shall have two years from the date of enactment to meet the requirements of Paragraph (4), with the commissioner having the authority to adjust at any time, in response to inflation, the trust fund amounts required in Paragraph (4), as follows:

(a) By December 31, 1998, the trust fund requirement shall be fifteen percent of surplus lines liabilities in the United States, excluding those types of liabilities set forth in R.S. 22:1249.1(C)(4), with a maximum of thirty million dollars.

(b) By December 31, 1999, the trust fund requirements shall be thirty percent of surplus lines liabilities in the United States, excluding those types of liabilities set forth in R.S. 22:1249.1(C)(4), with a maximum of sixty million dollars.

(6) In addition to all of the other requirements of this Section, an insurer not domiciled in the United States or its territories shall be listed by the International Insurers Department of the National Association of Insurance Commissioners. The commissioner may waive the requirement in this Paragraph or the requirements of Subparagraph B(4)(b) of this Section upon an affirmative finding of acceptability by the commissioner if the commissioner is satisfied that the placement of insurance with the insurer is necessary and will not be detrimental to the public and the policyholder. In determining whether business may be placed with the insurer, the commissioner may consider such factors as:

(a) The interests of the public and policyholders.

(b) The length of time the insurer has been authorized in its domiciliary jurisdiction and elsewhere.

(c) Unavailability of particular coverages from authorized insurers or unauthorized insurers meeting the requirements of this Section.

(d) The size of the company as calculated by its assets, capital and surplus, reserves, premium writings, insurance in force or other appropriate criteria; the kinds of business the company writes, its net exposure and the extent to which the business of the company is diversified among several lines of insurance and geographic locations.

(e) The past and projected trend in the size of the company's capital and surplus of the company considering such factors as premium growth, operating history, loss and expense ratios, or other appropriate criteria.

(7) Has caused to be provided to the commissioner a copy of its current annual statement certified by the insurer and an actuarial opinion as to the adequacy of, and methodology used to determine, the loss reserves of the insurer. The statement shall be provided at the same time it is provided to the insurer's domicile, but in no event more than eight months after the close of the period reported upon, and shall be certified as a true and correct copy by an accounting or auditing firm licensed in the jurisdiction of the insurer's domicile and certified by a senior officer of the unauthorized insurer as a true and correct copy of the statement filed with the regulatory authority in the domicile of the unauthorized insurer. In the case of an insurance exchange qualifying under Subparagraph B(1)(e) of this Section, the statement may be an aggregate combined statement of all underwriting syndicates operating during the period reported.

C. REPEALED BY ACTS 1997, No. 1340, §2, eff. July 15, 1997.

D. In addition to any other statements or reports required by this Chapter, the commissioner of insurance may request from any licensee full and complete information respecting the financial stability, reputation and integrity of any unauthorized insurer with whom any such licensee has dealt, or proposes to deal, in the transaction of insurance business. The licensee shall promptly furnish in written or printed form so much of the information requested as he can produce. The commissioner of insurance, if he believes it to be in the public interest, may order such licensee in writing to place no further insurance business on Louisiana risks through such unauthorized company.

E-G. REPEALED BY ACTS 1997, No. 1340, §2, eff. July 15, 1997.

H.(1) Notwithstanding any law to the contrary, no person shall act in this state as agent for or broker to any unauthorized insurer which has not been approved by the Department of Insurance in accordance with this Section and R.S. 22:1262.1, unless the following criteria are met:

(a) The insurance is limited to commercial property and liability, including commercial marine.

(b) The insurance coverage is excess coverage and the attachment point is at least twenty five million dollars for property and ten million dollars for liability or such other amount as the Department of Insurance in its discretion shall require.

(c) Approval from the Department of Insurance is required for each policy.

(d) The insured has been informed in writing by the agent or broker that the insurer has not been approved by the Department of Insurance.

(2) The commissioner by regulation or directive, may require that the insured meet minimum financial requirements and may require certification from the agent or broker that the insurer meets the financial and any other requirements promulgated by the Department of Insurance for insurance coverage by an unauthorized insurer which has not been approved by the Department of Insurance under this Section and R.S. 22:1262.1.

Acts 1958, No. 125. Amended by Acts 1960, No. 148, §1; Acts 1966, No. 175, §1; Acts 1972, No. 239, §1; Acts 1979, No. 196, §1; Acts 1981, No. 856, §1; Acts 1983, No. 714, §1; Acts 1993, No. 902, §1; Acts 1995, No. 819, §1; Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996; Acts 1997, No. 1340, §§1, 2, eff. July 15, 1997; Acts 1999, No. 868, §1.

*As appears in enrolled bill

§1262.1. Approved unauthorized insurers; list; requirements; removal

A. No surplus line broker shall place surplus line insurance with an insurer who is not on the list of approved unauthorized insurers as compiled and maintained by the commissioner of insurance.

B.(1) To obtain and maintain placement on the list of approved unauthorized insurers, a foreign insurer shall comply with the provisions of R.S. 22:1262 applicable to foreign insurers and shall annually file with the commissioner the following:

(a) A copy of the insurer's annual statement, signed and sworn to by its president and secretary as to its condition as of the preceding December thirty-first, evidencing that the insurer has capital and surplus of not less than fifteen million dollars exclusive of either surplus debentures or subordinated notes, and complied with the provisions of R.S. 22:1262(B)(7).

(b) Evidence that the amount of net premiums written does not exceed four times the insurer's capital and surplus.

(c) Evidence that, if the insurer issues workers' compensation insurance in this state, it has established and maintained a workers' compensation claims office pursuant to R.S. 23:1161.1 or has retained a licensed claims adjuster.

(d) A copy of the producer production report in a form required by the commissioner listing all business placed with the company by licensed surplus lines brokers. The report shall be filed with the Department of Insurance no later than April fifteenth of each year.

(2) An insurer that fails to file a copy of its annual statement on or before March 1st of each year shall be removed from the list of approved unauthorized insurers. The commissioner may grant an extension, not to exceed thirty days, if presented with satisfactory evidence showing the reasonableness o f the extension.

C. To obtain and maintain placement on the list of approved unauthorized insurers, an alien insurer shall comply with the provisions of R.S. 22:1262 applicable to alien insurers including but not limited to the provisions of R.S. 22:1262(B)(7), and the commissioner may require an alien insurer to file a copy of the producer production report in a form prescribed by the commissioner listing all business placed with the company by licensed surplus lines brokers. The report shall be filed with the Department of Insurance no later than April fifteenth of each year. The commissioner shall remove any alien insurer from the list of approved unauthorized insurers if it ceases to comply with the provisions of R.S. 22:1262 applicable to alien insurers, or if he determines that continued placement of surplus lines insurance with the insurer would not be in the best interest of the policyholders or citizens of Louisiana.

D. The commissioner shall remove a foreign insurer from the list of approved unauthorized insurers if:

(1) The insurer does not have capital and surplus of at least fifteen million dollars exclusive of surplus debentures and subordinated notes, as determined by his examiners.

(2) It is determined that the continued placement of surplus line insurance with the insurer would not be in the best interest of the policyholders or the citizens of Louisiana.

E. The commissioner may remove a foreign insurer from the list of approved unauthorized insurers if:

(1) The amount of net premiums written exceeds four times the insurer's capital and surplus.

(2) The insurer fails to deliver any information requested by the commissioner within thirty days.

(3) The insurer issues workers' compensation insurance within the state, and fails to establish and maintain a workers' compensation claims office pursuant to R.S. 23:1161.1 or fails to retain a licensed claims adjuster.

F.(1) The commissioner may declare an approved unauthorized insurer ineligible if at anytime he determines any of the following:

(a) The insurer is in unsound financial condition or has acted in an untrustworthy manner.

(b) The insurer no longer satisfies the requirements set forth in R.S. 22:1262.

(c) The insurer has willfully violated the laws of this state.

(d) The insurer does not conduct a proper claims practice.

(2) Repealed by Acts 2005, No. 167, §2, eff. June 28, 2005.

G. Upon removing an insurer from the list of approved unauthorized insurers, the commissioner shall notify the insurer and all licensed surplus lines brokers of such action in writing. Such notice to licensed surplus line brokers may, at the option of the surplus lines broker, be sent by the commissioner via electronic mail.

H. The commissioner shall have the authority to adopt and promulgate such rules and regulations as are necessary to carry out the provisions of this Section in accordance with the Administrative Procedure Act.

Acts 1985, No. 432, §1, eff. July 10, 1985; Acts 1990, No. 885, §1; Acts 1993, No. 902, §1; Acts 1997, No. 310, §1; Acts 1997, No. 1340, §1, eff. July 15, 1997; Acts 2004, No. 466, §1, eff. January 1, 2005; Acts 2005, No. 167, §§1 & 2, eff. June 28, 2005.

§1263. Records of surplus line broker

Each licensed surplus line broker shall keep a full and true record of each surplus line contract, procured by him including a copy of the daily report, if any, showing such of the following items as may be applicable:

(1) Amount of the insurance;

(2) Gross premiums charged;

(3) Return premium paid, if any;

(4) Rate of premium charged upon the several items of property;

(5) Effective date of the contract, and the terms thereof;

(6) Name and address of the insurer;

(7) Name and address of the insured;

(8) Brief general description of property insured and where located;

(9) Other information as may be required by the commissioner of insurance, including but not limited to the address of the worker's compensation claims office established by the insurer pursuant to R.S. 23:1161.1 and the name and address of the person authorized by the insurer to settle worker's compensation claims through such office or of the licensed claims adjuster retained by the insurer.

The record shall at all times be open to examination by the commissioner of insurance and whenever an examination shall be made by him of a surplus line broker, such examination shall be in compliance with and pursuant to the provisions of Part XXVIII* of this Title, insofar as the provisions of that Part are applicable to such examination.

Acts 1958, No. 125; Acts 1990, No. 885, §1; Acts 2004, No. 466, §1, eff. January 1, 2005.

*R.S. 22:1301 to 22:1314.

§1263.1. Proof of uninsurability; affidavit

A. Any licensed surplus lines broker that procures a personal lines policy with an approved unauthorized insurer shall obtain from the duly licensed submitting agent or broker within thirty days of binding an affidavit on a standardized form promulgated by the commissioner of insurance which shall be maintained by the licensed surplus lines broker that attests to the diligent efforts of the agent or broker to place insurance coverage with admitted insurers and the results thereof. The affidavit shall affirm that the insured applicant for insurance was expressly advised prior to placement of insurance that the surplus lines insurer with whom the insurance is being placed is an approved unauthorized insurer, and that in the event of insolvency of the insurer, losses shall not be paid by the state insurance guaranty fund, and that the coverage is being procured through a duly licensed Louisiana surplus lines broker.

B. As long as the personal lines policy continues to be renewed by the same approved unauthorized insurer, there shall not be a need for new affidavits at each renewal. At renewal, if the personal lines policy is placed with a different approved unauthorized insurer, then the procurement of a new affidavit will be secured in the manner outlined in Subsection A of this Section.

Acts 1993, No. 126, §1; Acts 1999, No. 868, §1.

§1264. REPEALED BY ACTS 1999, No. 868, §2.

§1265. Tax on surplus lines

A.(1) On or before March first, June first, September first, and December first of each year, each surplus lines broker shall transmit to the commissioner of insurance a surplus lines tax report for the prior calendar quarter. This report shall be in a manner and format prescribed by the commissioner of insurance and include any additional information as required by the commissioner. The reporting of transactions shall be as follows:

(a) All new and renewal policies will be included in the report for the calendar quarter in which the effective date of the policy falls.

(b) All other premium transactions will be included in the report for the calendar quarter in which the invoice falls.

(2) Along with the report required to be filed on the due dates provided in Paragraph (1) of this Subsection, each surplus lines broker shall remit to the commissioner of insurance a tax on the premiums on surplus lines insurance reported in the quarterly surplus lines tax report, at the rate of five percent per annum. Such tax when collected by the commissioner of insurance shall be paid to the state treasurer and be credited to the general fund.

B. Every person placing insurance with an unauthorized insurer without going through a licensed Louisiana agent or broker, except as provided in R.S. 22:1257, shall remit to the commissioner of insurance a tax of five percent of the gross premium, such tax to be paid at the same time and under the same conditions as that levied on surplus lines brokers under the provisions of Subsection A of this Section. Such tax when collected by the commissioner of insurance shall be paid to the state treasurer and be credited to the general fund.

C. If a surplus line policy covers risks or exposures only partially in this State the tax so payable shall be computed upon the proportion of the premium which is properly allocable to the risks or exposures located in this State.

D. The tax imposed on surplus lines under this Section shall not apply to the purchase of excess insurance obtained by an interlocal risk management agency pursuant to R.S. 33:1359 or 1485.

Acts 1958, No. 125. Amended by Acts 1958, No. 265, §1; Acts 1960, No. 149, §1; Acts 1984, 1st Ex. Sess., No. 3, §1, eff. March 27, 1984; Acts 1999, No. 868, §1; Acts 2005, No. 294, §1.

§1266. Penalty for failure to file statement or remit tax

In case of any failure of a surplus line broker to make a report or to make payment of the tax provided by R.S. 22:1265, ten percentum shall be added to the amount of tax due, and paid to the commissioner of insurance along with the tax due, unless evidence to his satisfaction is submitted to him to show that such failure was due to some unforeseen or unavoidable reason other than mere neglect. If the delinquency be for more than thirty days after the due date of the report or after the due date for the payment of taxes as provided by R.S. 22:1265, neglect will be presumed and the ten percentum shall be added without any discretion on the part of the commissioner of insurance. After the lapse of thirty days, until the report is filed and the delinquent tax paid, the commissioner of insurance may revoke the license of the delinquent surplus line broker to do business in this state. Any fine collected by the commissioner of insurance hereunder shall be paid to the state treasurer and credited to the general fund.

Acts 1958, No. 125. Amended by Acts 1966, No. 176, §1.

§1267. Suspension or revocation of licenses; surplus lines broker; fines

A. The commissioner of insurance shall revoke any surplus lines broker's license:

(1) If the broker fails to comply with R.S. 22:1265 or to remit required taxes on surplus lines premiums as required by this Part.

(2) If the broker fails to maintain the required records and accounts from this state as prescribed by R.S. 22:1263, or to allow the commissioner of insurance to examine his records as required by this Part.

(3) For closing of the surplus line broker's office for a period of more than thirty calendar days, exclusive of legal holidays, Saturdays, and Sundays, unless permission is granted by the commissioner.

(4) For failure to make and file required reports.

(5) For violation of any of the provisions of this Part.

(6) For any other cause for which an insurance license could be denied, revoked, suspended, or the renewal thereof refused under the provisions of R.S. 22:1142.

B. The commissioner of insurance may deny, suspend, revoke, or refuse to renew or reinstate any such license whenever he deems such denial, suspension, revocation, or refusal to renew or reinstate to be for the best interest of the people of this state. The agent's or producer's license may also be denied, suspended, revoked, or refused renewal or reinstatement whenever there is a denial, suspension, revocation, or refusal to renew or reinstate a surplus line broker's license.

C. The procedures provided by this Code for the denial, suspension, revocation, or refusal to renew or reinstate an agent's or producer's license shall be applicable to denial, suspension, revocation, or refusal to renew or reinstate a surplus line broker's license. The procedures provided for by this Code for the levying of fines against an agent or producer shall be applicable to the levying of fines against a surplus line broker.

D. No surplus line broker whose license has been so revoked, suspended, or refused renewal or reinstatement shall again be so licensed within one year thereafter, nor until any fines or delinquent taxes owing by him have been paid.

Acts 1958, No. 125. Amended by Acts 1966, No. 177, §1; Acts 1985, No. 717, §1; Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996; Acts 1999, No. 868, §1; Acts 2001, No. 386, §1; Acts 2004, No. 466, §1, eff. January 1, 2005.

§1268. Legal process against surplus line insurer

A. An unauthorized insurer shall be sued, upon any cause of action arising in this state under any contract issued by it as a surplus line contract, pursuant to this Part, in the district court of the parish in which the cause of action arose.

B. Service of legal process against the insurer may be made in any such action by service upon the secretary of state or some other person in his office whom he may designate during his absence. The secretary of state shall forthwith mail the documents of process served, or a true copy thereof, to the person designated by the insurer in the policy for the purpose by prepaid registered mail with return receipt requested. The insurer shall have forty days from the date of service upon the secretary of state within which to plead, answer, or otherwise defend the action. Upon service of process upon the secretary of state in accordance with this provision, the court shall be deemed to have jurisdiction in personam over the insurer.

C. An unauthorized insurer issuing such policy shall be deemed thereby to have authorized service of process against it in the manner and to the effect as provided in this Section. Any such policy shall contain a provision stating the substance of this Section, and designating the person to whom the secretary of state shall mail process as provided in Subsection B of this Section.

Acts 1958, No. 125.

§1269. Exemptions

A. The provisions of R.S. 22:1256 through 1268 and 1270 controlling the placing of insurance with unauthorized insurers shall not apply to reinsurance or to the following insurances when so placed by licensed surplus lines brokers of this state, except that a tax on the portion of the premiums received from ocean marine and foreign trade coverages which is properly allocable to the risks or exposures located in this state during the preceding calendar quarter shall be due on the dates and in a manner as provided in R.S. 22:1265 at the rate of five percent, such tax when collected by the commissioner of insurance shall be paid to the state treasurer and to be credited to the state general fund, and such licensed surplus lines broker placing ocean marine insurance shall be subject to the provisions of R.S. 22:1262, notwithstanding the provisions of R.S. 22:1249, 1249.1, and 1252, and must show on any document issued by and/or delivered by them evidencing such insurance, all of the insurers and must clearly stamp on any such documents that on the demand of the assured or its representative the latest financial statements of any such insurers are available at its office for inspection as follows:

(1) Ocean marine and foreign trade insurance.

(2) Insurance on subjects located, resident, or to be performed wholly outside of this state, or on vehicles or aircraft owned and principally garaged outside of this state.

(3) Insurance on property or operation of railroads engaged in interstate commerce.

(4) Insurance of aircraft owned or operated by manufacturers of aircraft, or of aircraft operated in scheduled interstate flight, or cargo of such aircraft, or against liability, other than worker's compensation and employer's liability, arising out of the ownership, maintenance, or use of such aircraft.

B. Surplus line brokers so placing any such insurance with an unauthorized insurer shall keep a full and true record of each such coverage in detail as required of surplus line insurance under this Part. The record shall be preserved for not less than five years from the effective date of the insurance and shall be kept available in this state and open to the examination of the commissioner of insurance. The surplus line broker shall furnish to the commissioner of insurance at his request and on forms as designated and furnished by him a report of all such coverages so placed in a designated calendar year.

Notwithstanding anything to the contrary herein contained, the rates for the exempt lines of insurance set out in Subsection A(1), (2), (3) and (4) shall not be regulated.

Acts 1958, No. 125. Amended by Acts 1958, No. 264, §1; Acts 1960, No. 183, §1; Acts 1970, No. 185, §1; Acts 1983, 1st Ex. Sess., No. 1, §6; Acts 1986, No. 749, §1; Acts 1999, No. 868, §1.

§1270. Records of insureds

Every person for whom insurance has been placed with an unauthorized insurer pursuant to or in violation of this Part shall, upon the commissioner of insurance's order, produce for his examination all policies and other documents evidencing the insurance, and shall disclose to the commissioner of insurance the amount of the gross premiums paid or agreed to be paid for the insurance. For each refusal to obey such order, such person shall be liable for a fine of not more than five hundred dollars.

Acts 1958, No. 125.

§1271. Tontine funds; sales prohibited

A. On and after July 29, 1964, the sale by any individual, company, partnership, corporation, non-profit corporation or insurance company of tontine funds whereby any part of the principal or interest earned on individual contributions is to be used for the benefit of other contributors is hereby prohibited.

B. Nothing herein contained shall in any way be construed as prohibiting the sale of insurance policies approved for use in the State of Louisiana by the Commissioner of Insurance.

Added by Acts 1964, No. 385, §§1, 2.

PART XXVIII. EXAMINATIONS AND INVESTIGATIONS

§1301. Commissioner of insurance to examine insurers, agents, and brokers

A.(1) The commissioner of insurance shall make an examination, not less frequently than once every five years, of all insurers doing business in this state at such times as prescribed by the provisions of this Part and at any other time when in the opinion of the commissioner it is necessary for such an examination to be made. The commissioner shall make a timely examination of an insurer upon presentation to him of a resolution approved by a majority of the board of directors of the Louisiana Insurance Guaranty Association or the Louisiana Life and Health Insurance Guaranty Association requesting that such an examination be made of a designated insurer.

(2) The commissioner may make an examination of any agent or broker doing business in this state whenever he has received at least three complaints within a thirty-day period that the agent or broker is not acting in conformance with this Code.

(3) For purposes of completing an examination of any company under this Part, and in addition to any other power granted to the commissioner by the Louisiana Insurance Code, the commissioner may examine or investigate any person, as defined in R.S. 22:1002(7), or the business of any person, in so far as such examination or investigation is, in the sole discretion of the commissioner, necessary or material to the examination of the company.

B. The commissioner of insurance may examine once in each six months for the first three years after organization or incorporation, and once in each year for the fourth through sixth years after organization or incorporation, and thereafter in accordance with the applicable provisions of this Part, all domestic insurers formed under the laws of this state.

C. In lieu of an examination under this Section of any foreign or alien insurer licensed in this state, the commissioner may accept an examination report on the company as prepared by the insurance department for the company's state of domicile or port-of-entry state, until January 1, 1994. Thereafter, such reports may only be accepted if:

(1) The insurance department was, at the time of the examination, accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program.

(2) The examination is performed under the supervision of an accredited state insurance department, or with the participation of one or more examiners who are employed by such an accredited state insurance department, and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

D. Upon determining that an examination should be conducted, the commissioner shall appoint one or more examiners to perform the examination and instruct them as to the scope of the examination. In conducting the examination, the examiner or examiners shall observe those guidelines and procedures set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners. The commissioner may also employ such other guidelines or procedures as the commissioner may deem appropriate.

E. Nothing contained in this Part shall be construed to limit the commissioner's authority to use any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the commissioner may, in his sole discretion, deem appropriate.

F. Nothing contained in this Part shall be construed to limit the authority of the commissioner to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

Acts 1958, No. 125. Amended by Acts 1979, No. 702, §1; Acts 1989, No. 665, §1, eff. Sept. 1, 1989; Acts 1992, No. 811, §1; Acts 1999, No. 1304, §1, eff. July 12, 1999.

§1301.1. Examination of self-insured worker's compensation insurance program

A. Every provider of a self-insured worker's compensation insurance program pursuant to R.S. 23:1191 shall apply for a certificate of authority.

B. Upon receipt of the application for a certificate of authority, the commissioner of insurance shall cause an initial examination to be made of the corporation. If, in the opinion of the commissioner of insurance, the examination shows the corporation to be duly organized and to have complied with all requirements of this Code, he shall notify the applicant and issue a certificate of authority to the corporation, upon payment of the fee stipulated in R.S. 22:1078(B)(13).

C. Existing programs of self-insured worker's compensation shall make application within ninety days from the effective date of this Section.

D. Providers of self-insured worker's compensation insurance programs pursuant to R.S. 23:1191, operating on the effective date of this Section are exempt from the provisions of R.S. 22:1078(B)(13).

Added by Acts 1983, 1st Ex. Sess., No. 18, §2.

§1302. Examination reports

A. All examination reports shall be comprised of facts only appearing upon the books, records, or other documents of the company, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

B. Not later than sixty days following completion of the examination, the examiner in charge shall file with the Department of Insurance a verified written report of examination under oath. Upon receipt of the verified report, the Department of Insurance shall transmit the report to the company examined, together with a notice, which shall afford the company examined a reasonable opportunity, of not more than thirty days, to make a written submission or rebuttal with respect to any matters contained in the examination report.

C. Within thirty days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers and enter an order:

(1) Adopting the examination report as filed, or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, rule, regulation, or prior order or directive of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure such violation.

(2) Rejecting the examination report with direction to the examiners to reopen the examination for purposes of obtaining additional documentation, data, information, and testimony.

D. Within thirty days of rejection by the commissioner of an examination report in accordance with Subsection C(2) of this Section, unless the commissioner extends such time for reasonable cause, the examiner in charge shall refile with the Department of Insurance a verified written report of examination, as may be modified or corrected, under oath. Upon receipt of the refiled verified report, the Department of Insurance shall transmit the refiled report to the company examined, together with a notice similar to the notice provided for in Subsection B of this Section, except that the notice shall indicate that the report is a refiled report.

E. Within thirty days of the end of the period allowed for the receipt of written submissions or rebuttals, as provided for in Subsections B and D of this Section, the commissioner shall fully consider and review the refiled report, together with any written submissions or rebuttals and any relevant portions of the workpapers of the examiner and enter an order:

(1) Adopting the examination report as refiled or with modification or corrections. If the refiled examination report reveals that the company is operating in violation of any law, rule, regulation, or prior order or directive of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure such violations; or

(2) Rejecting the examination report and ordering a hearing pursuant to the provisions of Part XXIX of Chapter l of Title 22 of the Louisiana Revised Statutes of 1950, for purposes of obtaining additional documentation, data, information, and testimony.

F. All orders entered pursuant to Subsection C(1) or E(1) of this Section shall be accompanied by findings and conclusions resulting from consideration by the commissioner and review of the examination report, relevant examiner workpapers, and any written submissions or rebuttals. Any order shall be served upon the company by certified mail, together with a copy of the adopted examination report. Within thirty days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating, under oath, that they have received a copy of the adopted report and related orders.

G. Within thirty days of receipt of notification of the order of the commissioner to the company made pursuant to Subsection F of this Section, the company may make written demand for a hearing pursuant to the provisions of Part XXIX of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950.

H. The hearing provided for under Subsection E(2) or G of this Section shall be a confidential proceeding. At the conclusion of the hearing and in accordance with R.S. 22:1359, the commissioner shall enter an order adopting the examination report as filed or refiled, or with modification or corrections, and may order the company to take any action the commissioner considers necessary and appropriate to cure any violation of any law, regulation, or prior order of the commissioner.

I.(1) Upon the adoption of the examination report under either Subsection C(1), E(1), or H of this Section, the commissioner shall continue to hold the content of the examination report as private and confidential information for a period not to exceed thirty consecutive days, except to the extent provided in R.S. 22:1301(E) and Subsection B of this Section. Thereafter, the commissioner may open the report for public inspection so long as no court of competent jurisdiction has stayed its publication.

(2) Nothing contained in the Louisiana Insurance Code shall prevent, or be construed as prohibiting, the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of this or any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, so long as such agency or office receiving the report or matters relating thereto agrees, in writing, to hold it confidential and in a manner consistent with this Part.

(3) If the commissioner determines that regulatory action is appropriate as a result of any examination, he may initiate any proceedings or actions as provided by law.

J. All working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the commissioner, or any other person, in the course of an examination made under this Part, shall be given confidential treatment and are not subject to subpoena and may not be made public by the commissioner or any other person, except to the extent provided in R.S. 22:1301(E) and Subsection I of this Section. Any access may be granted to the National Association of Insurance Commissioners. The parties shall agree, in writing prior to receiving the information, to provide to it the same confidential treatment as required by this Section, unless the prior written consent of the company to which it pertains has been obtained.

K.(1) No examiner may be appointed by the commissioner if such examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this Part. This Section shall not be construed to automatically preclude an examiner from being:

(a) A policyholder or claimant under an insurance policy.

(b) A grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business.

(c) An investment owner in shares of regulated diversified investment companies.

(d) A settlor or beneficiary of a "blind trust" into which any otherwise impermissible holdings have been placed.

(2) Notwithstanding the requirements of this Section, the commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though said persons may from time to time be similarly employed or retained by persons subject to examination under this Part.

L.(1) No cause of action shall arise nor shall any liability be imposed against the commissioner, the authorized representatives of the commissioner, or any examiner appointed by the commissioner, for any statements made or conduct performed in good faith while carrying out the provisions of this Part. (2) No cause of action shall arise, nor shall any liability be imposed, against any person for the act of communicating or delivering information or data to the commissioner, or the authorized representative of the commissioner, or examiner, pursuant to an examination made under this Part, if such act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

Acts 1958, No. 125. Amended by Acts 1964, No. 137, §1; Acts 1992, No. 811, §1.

§1303. Commissioner of insurance to conduct annual office review of insurers

A. In addition to those examinations performed by the commissioner of insurance pursuant to R.S. 22:1301, the commissioner of insurance shall conduct an annual office review of all insurers authorized to do business in this state, other than life, health, and accident insurers and nonprofit funeral associations. Such office reviews shall include the annual statement of the insurer reviewed, company financial reports rendered pursuant to good and acceptable accounting practices, results of insurance solvency standards testing as performed by the National Association of Insurance Commissioners, results of prior examinations and office reviews, management changes, consumer complaints, and such other relevant information as from time to time may be required by the commissioner.

B. The commissioner shall timely furnish to each reviewed insurer a written report detailing the findings of each such annual review. Within forty-five days of its receipt of such written report, each reviewed insurer shall provide to the commissioner such response, rebuttal, explanation, or other information as it may see fit. The commissioner shall furnish to any person, upon request, a copy of the written report, accompanied by a copy of the response, rebuttal, explanation, or other information provided by the reviewed insurer.

Acts 1958, No. 125; Acts 1990, No. 259, §1.

{{**NOTE:** SEE ACTS 1990, NO. 259, §§2 AND 3, FOR EFFECTIVENESS AND APPLICABILITY.}}

§1304. Review and examination expense; how paid

A. Whenever the commissioner of insurance examines an insurer, or a third-party administrator for an insurer or self-insurance fund, other than a group self-insured fund provided for in R.S. 23:1195 et seq., all the expenses incurred by the commissioner of insurance in conducting such examination, including the expenses and fees of examiners, auditors, accountants, actuaries, attorneys, or clerical or other assistants who are employed by the commissioner of insurance to make the examination, shall be paid by the insurer or self-insurance fund examined. The commissioner shall likewise be entitled to recover from each reviewed insurer or self-insurance fund, the actual expenses incurred in conducting its annual office review. All funds so generated and collected shall be used only to defray the expenses of reviews and examinations and for no other purpose.

B. With respect to insurers, excluding self-insurance funds possessing less than one million dollars capital and surplus at the time of the examination, the commissioner of insurance shall, if requested by the insurer, conduct an administrative hearing pursuant to R.S. 22:1351 et seq. within fifteen days after the expenses and fees, excluding the costs of the actuarial certification of reserves, to be paid by the insurer total two thousand dollars. At the hearing it shall be determined whether the amount of expenses billed to the insurer are reasonable and it shall be determined whether the examination should continue. Nothing in this Subsection shall prevent an insurer from contesting the amount of expenses as provided in R.S. 22:1306.

C. The commissioner of insurance may recover all expenses incurred from the examination or investigation of any person or entity acting as an administrator or third-party administrator in this state for any insurer or self-insurance fund not authorized to transact the business of insurance in this state.

Acts 1958, No. 125; Acts 1990, No. 259, §1; Acts 1997, No. 1449, §1; Acts 2001, No. 488, §1.

§1305. Authority to employ examiners and other assistants

A. The commissioner of insurance shall employ such examiners, auditors, accountants, actuaries, attorneys, and clerical or other assistants as are necessary to conduct the examination and to compile and prepare a report thereon, and the compensation for such examination shall be fixed according to the time actually devoted to the work of conducting the examination and compiling the report thereon as now required by law. Such compensation shall always be reasonable and commensurate with the value of the services performed.

B. Personnel conducting an examination for financial condition shall be compensated for each day worked at rates no less than the rates provided in the procedural manual of the National Association of Insurance Commissioners or the rates applicable to such personnel under the state civil service pay schedule, whichever is greater. The chief examiner shall be compensated on the basis of one hundred fifteen percent of the insurance examiner in-charge CFE. The assistant chief examiner shall be compensated on the basis of one hundred ten percent of the insurance examiner in-charge CFE.

C. Upon completion of the examination of any insurer or at stated periods during such examinations, the commissioner of insurance shall forward to the insurer a statement showing the amount of expenses incurred in such examination to the date of such statement. Whereupon, the insurer shall pay the amount so shown to the commissioner of insurance. Upon receipt of such payment the commissioner of insurance shall deposit same in an account styled "commissioner of insurance, revolving fund account", and withdrawals from said account shall be made by the commissioner of insurance for the purpose of payment to examiners, auditors, accountants, actuaries, attorneys, and clerical or other assistants of their salaries and necessary expenses incurred in the conduction of such examination.

Acts 1958, No. 125; Acts 1991, No. 793, §1.

§1306. Insurer's right to contest expense

Should the insurer deem the amount of expenses billed to it unreasonable or contrary to the provisions of this Part, it may within fifteen days after the receipt of such billing, take a rule in a court of competent jurisdiction upon the commissioner of insurance to test the reasonableness and legality under this Part of the amount of expenses billed to it by the commissioner of insurance which rule shall be tried by preference, and upon appeal, shall be given preference in the appellate court, as provided by the laws of this state for other state cases.

Acts 1958, No. 125.

§1307. Failure to pay expenses; penalty

Should any insurer fail or refuse to pay the expenses of examination as billed by the commissioner of insurance after fifteen days upon receipt of such billing or after final judgment where a rule has been taken as provided herein, then the commissioner of insurance may revoke the certificate of authority of such insurer to do business in this state until the full amount of the bill is paid.

Acts 1958, No. 125.

§1308. Scope of examination

In conducting such an examination, the commissioner of insurance shall examine the affairs, transactions, accounts, records, documents and assets of each authorized insurer. Except in the case of a life insurer issuing only registered policies under R.S. 22:1029 for the purpose of ascertaining its condition or compliance with this Code, the commissioner of insurance may as often as he deems advisable, examine the accounts, records, documents and transactions of (1) any insurance agent, solicitor or broker, but only insofar as such accounts, records, documents and transactions relate to insurance, (2) any person having a contract under which he enjoys in fact the exclusive or dominant right to manage or control a stock or mutual insurer, (3) any person holding the shares of capital stock or policyholders' proxies of a domestic insurer for the purpose of control of its management either as voting trustee or otherwise, (4) any person engaged in or proposing to be engaged in or assisting in the proposed formation of a domestic insurer or an insurance holding corporation or a stock corporation to finance a domestic mutual insurer for the production of its business or the attorney-in-fact of a domestic reciprocal insurer.

Acts 1958, No. 125.

§1309. Production of books and records

Every insurer being examined, its officers, employees and representatives, shall produce and make freely accessible to the commissioner of insurance the accounts, records, documents and files in its possession or control relating to the subject of the examination, and shall otherwise facilitate the examination.

Acts 1958, No. 125.

§1310. Power to examine under oath; subpoena wi tnesses

The commissioner of insurance may take depositions, subpoena witnesses or documentary evidence, administer oaths and examine under oath any individual relative to the affairs of any insurer being examined. Any person who testifies falsely or makes any false affidavit during the course of such an examination shall be guilty of perjury.

Acts 1958, No. 125.

§1311. Rating organizations, examining license bureau, advisory organization, joint underwriters and joint reinsurance groups; examination of

As often as in the opinion of the commissioner of insurance it is believed necessary and at least once in every five years, the commissioner of insurance shall fully examine each rating organization and examining bureau licensed in this state. As often as he deems it advisable, he may examine each advisory organization and joint underwriting or joint reinsurance group, association or organization. The commissioner of insurance shall have the same power and authority in these examinations, and the examination shall be made in the same method as that provided herein for the examination of insurers.

Acts 1958, No. 125.

§1312. REPEALED BY ACTS 1992, NO. 811, §2.
§1313. REPEALED BY ACTS 1992, NO. 811, §2.
§1314. Commissioner of insurance authorized to employ investigators

The commissioner of insurance shall have authority to employ investigators to investigate complaints received against insurers authorized to do business in this state and against any unauthorized insurers who are reported to be operating in this state.

Acts 1958, No. 125.

§1315. Disclosure

A. It shall be unlawful for any person who is an officer, employee, agent, or representative of an insurer; or any person, partnership, corporation, banking corporation, or any other legal entity which performs any service for an insurer, or prepares any report, audit, financial statement or report for, or makes any representation on behalf of, for, or with regard to an insurer, in connection with any hearing, investigation, or examination authorized by this Code, to act with the specific intent to:

(1) Represent falsely, directly or indirectly, to the Department of Insurance or any employee or administrator thereof that an asset of such insurer is unencumbered, or to misrepresent any other material fact pertaining to the status of any asset or liability of an insurer.

(2) Materially misrepresent to the Department of Insurance, or any employee or administrator thereof, the value of any asset or the amount of any liability of such insurer, or any affiliate, subsidiary, or holding company associated therewith; provided that with regard to a material misrepresentation of the value of any asset or liability, any deviation from the actual value of such asset or liability which results from utilization of and compliance with generally accepted insurance accounting and reporting procedures shall not be deemed a violation of this Section.

(3) Fail to disclose to the Department of Insurance the existence of any liability of an insurer, or affiliate, subsidiary, or holding company associated therewith when such disclosure is properly requested or required in writing by an examiner or administrator of the Department of Insurance, or

(4) Materially misrepresent, withhold, deny access to, or otherwise preclude the obtainment of any information properly requested in writing and in accordance with provisions of the Louisiana Revised Statutes affecting dissemination or disclosure of information by specific institutions by an examiner or administrator of the Department of Insurance, which is material and relevant to an examination properly conducted by the Department of Insurance and examiners and administrators thereof.

B. Whoever violates any provision of this Section, upon conviction, shall be fined not more than fifty thousand dollars, or imprisoned with or without hard labor for not more than five years, or both.

Added by Acts 1979, No. 118, §1. Acts 1992, No. 1114, §1.

§1316. Departmental complaint directives; failure to comply; fines; hearing

A. Any person subject to the regulatory authority of this department who fails to comply with any directive issued by the commissioner in connection with a consumer complaint shall be fined an amount not to exceed two hundred fifty dollars for each occurrence.

B. Any person against whom a fine has been levied shall be given notice of such action. Upon receipt of this notice, the person aggrieved may apply for and shall be entitled to a hearing pursuant to R.S. 22:1351 et seq.

Acts 1990, No. 773, §1.

PART XXVIII-A. AUDITED FINANCIAL REPORTS LAW

§1321. Title

This Part shall be known and may be cited as the "Audited Financial Reports Law".

Acts 1990, No. 264, §1.

§1322. Purpose and scope

The purpose of this Part is to improve the commissioner's surveillance of the financial condition of insurers by requiring an annual examination by independent certified public accountants of the financial statements reporting the financial condition and the results of operations of insurers.

Acts 1990, No. 264, §1; Acts 1992, No. 811, §1; Acts 1995, No. 595, §1, eff. June 18, 1995.

§1323. Audited financial report

By June first of each year, every admitted insurer in the state shall file an annual financial report for the immediately preceding year ending December thirty-first, audited by a certified public accountant as required by the National Association of Insurance Commissioners, as evidenced by its annual statement instruction handbook. The commissioner may determine and require that additional information be submitted in the annual financial report.

Acts 1990, No. 264, §1; Acts 1995, No. 595, §1, eff. June 18, 1995.

§1324. Exemptions and filing dates

A.(1) The commissioner shall grant an exemption from the provisions of this Part if:

(a) After written application for an exemption submitted by an insurer, the commissioner determines that compliance with this Part would constitute a financial or organizational hardship on the insurer; or

(b) The insurer is a domestic life insurer which does business exclusively in the state of Louisiana, with gross annual premiums totaling twenty million dollars or less and has entered into reinsurance agreements having a net aggregate amount of five million dollars or less and has admitted assets of less than twenty-five million dollars. No domestic life insurer under this Subsection that fails to satisfy the financial solvency requirements promulgated by the Department of Insurance shall be exempt from the provisions of this Part, including the submission of annual audited financial statements.

(2) An exemption may be granted, in writing, at any time and from time to time for a specified period or periods.

(3) Within ten days after a denial of the written request for an exemption from this Part, the insurer may request, in writing, a hearing on its application for an exemption. The hearing shall be held in accordance with Part XXIX of the Louisiana Insurance Code.

B. Upon written application of an insurer, the commissioner may permit an insurer to file annual financial reports for specified periods on another basis other than a calendar year basis. Within ten days from a denial of such a written request, the insurer may request, in writing, a hearing on its application. The hearing shall be held in accordance with Part XXIX of the Louisiana Insurance Code.

Acts 1990, No. 264, §1; Acts 1995, No. 595, §1, eff. June 18, 1995.

§1325. Rules and regulations

The commissioner shall adopt reasonable rules and regulations for the implementation and administration of the provisions of this Part in accordance with the Louisiana Administrative Procedure Act, R.S. 49:950 et seq.

Acts 1990, No. 264, §1; Acts 1995, No. 595, §1, eff. June 18, 1995.

§1326. REPEALED BY ACTS 1995, No. 595, §2, eff. June 18, 1995.
§1327. REPEALED BY ACTS 1995, No. 595, §2, eff. June 18, 1995.
§1328. REPEALED BY ACTS 1995, No. 595, §2, eff. June 18, 1995.
§1329. REPEALED BY ACTS 1995, No. 595, §2, eff. June 18, 1995.
§1330. REPEALED BY ACTS 1995, No. 595, §2, eff. June 18, 1995.
§1331. REPEALED BY ACTS 1995, No. 595, §2, eff. June 18, 1995.
§1332. REPEALED BY ACTS 1995, No. 595, §2, eff. June 18, 1995.
§1333. REPEALED BY ACTS 1995, No. 595, §2, eff. June 18, 1995.
§1334. REPEALED BY ACTS 1995, No. 595, §2, eff. June 18, 1995.
§1335. REPEALED BY ACTS 1995, No. 595, §2, eff. June 18, 1995.

PART XXIX. ADMINISTRATIVE ORDERS, HEARING AND APPEALS

§1351. Hearings

The commissioner of insurance, or any qualified employee of the insurance department designated by him for the purpose, may hold a hearing for any purpose within the scope of this Code as he may deem necessary. He shall hold a hearing:

(1) If required by any provision of this Code, or

(2) Upon written demand for a hearing made by any person aggrieved by any act, threatened act, or failure of the commissioner of insurance to act, if such failure is deemed an act under any provision of this Code, or by any report, promulgation, or order of the commissioner of insurance other than an order on a hearing of which such person was given actual notice or at which such person appeared as a party, or order pursuant to the order on such hearing.

(a) Any such demand for a hearing shall specify in what respects such person is so aggrieved and the grounds to be relied upon as basis for the relief to be demanded at the hearing.

(b) The commissioner of insurance, or any department employee designated by him for that purpose, shall hold such hearing demanded within thirty days after his receipt of the demand, unless postponed by mutual consent, or upon motion of either party for good cause shown. In no circumstance shall this hearing be held later than sixty days from the date of the original demand for the hearing unless otherwise agreed upon by all parties.

(c) Any demand for such hearing shall be made within thirty days of receipt of actual notice or, if actual notice is not received, within thirty days of the date such person learned of the act upon which the demand for hearing is based as described in this Paragraph.

Acts 1958, No. 125. Amended by Acts 1964, No. 150, §1; Acts 1992, No. 695, §1.

§1352. Stay of action

A. Such demand for a hearing received by the commissioner of insurance prior to the effective date of action taken or proposed to be taken by him shall stay such action pending the hearing, except as to action taken or proposed:

(1) Under an order on hearing, or

(2) Under an order pursuant to an order on hearing, or

(3) Under an order to make good an impairment of the capital funds of an insurer.

B. In any case where an automatic stay is not provided for, and if the commissioner of insurance after written request therefor fails to grant a stay, the person aggrieved thereby may apply to the district court in and for the parish of East Baton Rouge for a stay of the commissioner of insurance's action.

Acts 1958, No. 125.

§1353. Hearing place, public

The hearing shall be held at the place designated by the commissioner of insurance, and at his discretion it may be open to the public.

Acts 1958, No. 125.

§1354. Notice of hearing

A. The commissioner of insurance shall, not less than five days in advance, give notice to an insolvent domestic insurance company to be affected by the hearing of the time and place thereof and specifying the matters to be considered at the hearing in connection with such insolvency.

B. In all other cases, the commissioner of insurance shall, not less than ten days in advance, give notice to each person to be affected by the hearing of the time and place thereof and specifying the matters to be considered at the hearing.

C. If under Subsection B of this Section, notice of a hearing would be required to be given to more than one hundred persons, in lieu of the notice provided for in such Subsection and for the purposes of Part XXVI,[1] only, the commissioner of insurance may give notice of the hearing by publishing the notice in a daily newspaper in each of the congressional districts of the state at least once each week during the four weeks immediately preceding the week in which the hearing is to be held.

Any such published notice shall state the time and place of the hearing and shall specify the matters to be considered thereat.

Acts 1958, No. 125. Amended by Acts 1960, No. 153, §1.

[1]R.S. 22:1211 to 22:1220.

§1355. Show cause notice

If any person is entitled to a hearing by any provision of this Code before any proposed action is taken, the notice of the proposed action may be in the form of a notice to show cause stating that the proposed action may be taken, unless such person shows cause at a hearing to be held as specified in the notice why the proposed action should not be taken, and stating the basis of the proposed action.

Acts 1958, No. 125.

§1356. Adjourned hearing

The commissioner of insurance may adjourn any hearing from time to time and from place to place without other notice of the adjourned hearing than announcement thereof at the hearing.

Acts 1958, No. 125.

§1357. Non-attendance

The validity of any hearing held in accordance with the notice thereof shall not be affected by failure of any person to attend or to remain in attendance.

Acts 1958, No. 125.

§1358. Procedure

A. The commissioner of insurance, or any insurance department employee designated by him for the purpose, shall preside at the hearing and shall keep a true and concise record of the proceedings thereat. Formal rules of pleading or evidence need not be observed at the hearing.

B. In the conduct of any hearing provided for by this Code, the commissioner of insurance or other employee designated by him for that purpose, shall have power to compel the attendance of any person by subpoena, to administer oaths and to examine any person under oath concerning the business, conduct, or affairs of any company or persons subject to the provisions of this Code, and in connection therewith to require the production of any books, records, or papers relative to the inquiry. In all cases where witnesses are subpoenaed to attend any hearing under this section, they shall be notified by a summons issued and signed by the commissioner of insurance, or the insurance department employee designated to conduct such hearing, and mailed to them by registered mail, or which shall be served upon them when deemed necessary, by the sheriff of the parish where they reside or where they may be found, the same as in cases of service of a notice to a witness in a civil proceeding.

(1) If a person subpoenaed to attend such hearing fails to obey the command of the subpoena without reasonable excuse, or if a person in attendance upon such inquiry shall without reasonable cause, refuse to be sworn or to be examined or to answer a question or to produce a book or paper when ordered to do so by the person conducting such hearing, or if any person fails to perform any act required hereunder to be performed, he shall be required to pay a penalty of not less than $100.00 nor more than $2,000.00 at the discretion of the court, to be recovered in the name of the people of the State of Louisiana by the district attorney of the parish in which the violation occurs, and the penalty so recovered, less costs of court and expenses of the district attorney to be fixed by the court, shall be paid to the office of the commissioner of insurance.

(2) When any person neglects or refuses without reasonable cause to obey a subpoena issued by the commissioner of insurance, or refuses without reasonable cause to testify, or to be sworn or to produce any book or paper described in the subpoena, the commissioner may file a petition against such person in the district court of the parish in which the testimony is desired to be or has been taken or has been attempted to be taken, briefly setting forth the fact of such refusal or neglect and attaching a copy of the subpoena and the return of service thereon and applying for an order requiring such person to attend, testify, or produce the books or papers before the commissioner or the employee designated by him to hold a hearing, at such time or place as may be specified in such order. Such court, either during the term of court or vacation, upon filing of such petition, either before or after notice to such person, may, in the judicial discretion of such court, order the attendance of such person, the production of books and papers, and the giving of testimony before the commissioner or the person designated by him to conduct a hearing. If such person shall fail or refuse to obey the order of the court and it shall appear to the court that the failure or refusal of such person to obey its order is willful, and without lawful excuse, the court shall punish such person by fine or imprisonment in the parish jail, or both, as the nature of the case may require, as is now, or as may hereafter be lawful for the court to do in cases of contempt of court.

(3) The fees of witnesses for attendance and travel shall be the same as the fees of witnesses before the parish courts of this state. When a witness is subpoenaed by, or testifies at the instance of the commissioner or other person designated by him, such fees shall be paid in the same manner as other expenses of the insurance department. When a witness is subpoenaed or testifies at the instance of any other party to such hearing, the cost of the subpoena, subpoena duces tecum and the fee of the witness shall be borne by the party at whose instance the witness is summoned. In such case, the insurance department, in its discretion, may require a deposit to cover the cost of such service and witness fees.

C. At the expense of and at the written request reasonably made by any person affected by the hearing, the commissioner of insurance or the person designated by him to hold the hearing, shall cause a full stenographic record of the proceedings to be made by a competent stenographic reporter and if transcribed, such records shall be made a part of the record of the commissioner of insurance of the hearing.

D. The commissioner of insurance, or such person conducting the hearing, shall allow any person affected by the hearing to be present during the giving of all testimony and shall allow him a reasonable opportunity to inspect all documentary evidence, to examine witnesses, and to present evidence in support of his interests. Upon good cause shown, the officer conducting the hearing may permit any person to intervene, appear, and be heard at the hearing.

E. Any person heard shall make full disclosure of facts pertinent to the subject of inquiry as requested by the person holding the hearing or by any person affected by the hearing.

Acts 1958, No. 125. Amended by Acts 1964, No. 153, §1.

§1359. Order on hearing

A. Within thirty days after the termination of a hearing the commissioner of insurance shall make his order thereon and shall, subject to Sub-section D of this Section, give a copy of the order to each person to whom notice of the hearing was given or required to be given.

B. The order shall contain:

(1) A concise statement of the action taken.

(2) The effective date of such action.

(3) A designation of the provisions of this Code pursuant to which the action is taken.

(4) A concise statement of the findings of the commissioner of insurance in support of the action.

C. An order on hearing may confirm, modify or nullify actions taken under an existing order, or may constitute the taking of any new action coming within the scope of the notice of such hearing.

D. If notice of such hearing was given by publication as provided for in R.S. 22:1354, the commissioner of insurance may publish the order on hearing once each week for four successive weeks in the same newspapers in which such notice was published, the first such publication to be made on the date of the order. Such publication of the order on hearing shall be in lieu of the requirement that a copy of such order be given to each person as provided in Sub-section A of this Section.

Acts 1958, No. 125.

§1360. Review from commissioner of insurance's order

A. Any person aggrieved on account of any official action or threatened action of the commissioner of insurance, or of his failure to act if such failure is deemed to constitute an act under any provision of this Code, may demand a hearing thereon as provided in R.S. 22:1351, and may have the court review any order of the commissioner of insurance made pursuant thereto. The petition for such review shall be filed only in the district court in and for the parish of East Baton Rouge and shall be taken only from an order refusing a hearing or an order on hearing. Such action may be taken by any person aggrieved by such order refusing a hearing or by such order on hearing.

B. The action must be taken within thirty days after the order complained of was given by the commissioner of insurance, or, if the order was published as provided in R.S. 22:1359, within thirty days after the date of the last such publication. If not so taken, the right to have a court review or restrain action under the order shall conclusively be deemed to have been waived.

Acts 1958, No. 125.

§1361. How review taken

The legal action shall be taken by filing with the clerk of court of the parish of East Baton Rouge a petition for a review of the commissioner of insurance's order, containing a copy of the order and a statement of the particulars in which it is claimed that the order is in error and a statement of the relief prayed for. Service of such petition shall be made upon the commissioner of insurance in the manner provided by law.

Acts 1958, No. 125.

§1362. Record to court

Upon being served with a copy of the petition for review of an order on hearing, the commissioner of insurance shall forthwith prepare and file with the clerk of the court a true and complete transcript of his record of the hearing on which the order complained of was made. The cost of the transcript may be included in the cost allowed by the court.

Acts 1958, No. 125.

§1363. Hearing the case

The court shall give precedence to and may summarily hear and determine the case. The court shall hear the case upon the transcript of the record of the commissioner of insurance's hearing and on such additional proper evidence as may be offered by any party. After considering the evidence the court may affirm, modify or set aside the order. Costs shall be awarded as in civil cases.

Acts 1958, No. 125.

§1364. Stay of action on review

A. The filing of such a petition shall not stay any action taken or proposed to be taken by the commissioner of insurance under the order complained of unless a stay is granted by the court at a hearing held as part of the proceedings.

B. A stay shall not be granted by the court in any case where the granting of a stay would tend to injure the public interest. In granting a stay, the court may require of the person taking the action such security or other conditions as it deems proper.

C. If the order complained of is one suspending, revoking, or refusing to renew an agent's, broker's, or solicitor's license, the person taking the action, by filing a bond with the clerk of the court, subject to approval of the court, conditioned to pay all costs that may be awarded against him, may, if filed prior to the effective date of such order, supersede the order complained of until the final determination of the case. The court shall determine the amount of the bond by considering the severity of the charges or the amount of money allegedly involved in such charges.

Acts 1958, No. 125; Acts 1993, No. 956, §1.

§1365. Appeal to proper appellate court

An appeal may be taken to the proper appellate court as in civil actions from a judgment of the district court made pursuant to any provisions of this Part. Such appeal shall be advanced upon the trial calendar of the appellate court and be heard at the earliest convenient date.

Acts 1958, No. 125.

§1366. Use of injunctive process

The commissioner is empowered, also, to seek the enforcement of any lawful written order made pursuant to R.S. 22:1359, or to secure the prevention or discontinuance of any violation of a prohibitory or mandatory licensing provision of this Code by legal action for injunction which may be filed in the district court in either the parish of East Baton Rouge or the parish in which the offender is domiciled, and he shall be represented in such actions by the attorney general or the attorney for his department, if such there is.

Added by Acts 1966, No. 214, §1.

§1367. Writ of mandamus

Nothing contained in this Part shall deprive a person of his right, or delay the exercise of such right, to seek a writ of mandamus compelling the commissioner of insurance to perform a ministerial duty as established by law where it is alleged that the commissioner of insurance is fraudulently or not impartially fulfilling his duties, or where the delay involved in obtaining ordinary relief may cause injustice. No provision of this Part shall be a bar to, or grounds for delay, continuance, or deferral of the prompt adjudication of a petition for writ of mandamus directing the commissioner of insurance to do his duty.

Added by Acts 1979, No. 256, §1.

§1368. Administrative hearings

As provided in Chapter 13-B of Title 49 of the Louisiana Revised Statutes of 1950, the Division of Administrative Law shall conduct any adjudications required by any provision of this Part.

Acts 2003, No. 933, §1.

PART XXIX-A. INSURANCE GUARANTY ASSOCIATION FUND

§1375. Title

This Part shall be known and may be cited as the Insurance Guaranty Association Law.

Added by Acts 1970, No. 81, §1.

§1376. Purpose

The purpose of this Part is to provide a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer, to assist in the detection and prevention of insurer insolvencies and to allow the association to provide financial assistance to member insurers under rehabilitation or liquidation, and to provide an association to assess the cost of such operations among insurers.

Added by Acts 1970, No. 81, §1. Acts 1992, No. 517, §1, eff. June 25, 1992.

§1377. Scope; policy coverage determination

A. This Part shall apply to all kinds of direct insurance, except life, health and accident, title, disability, mortgage guaranty, financial guaranty, or other insurances offering protection against investment risks, credit insurance, and any transaction or combination of transactions which involve the transfer of investment or credit risks unaccompanied by the transfer of the insurance risk, vendor's single interest insurance, collateral protection insurance, or any similar insurance which protects the interests of a creditor arising out of a creditor-debtor transaction, vehicle mechanical breakdown insurance, and ocean marine insurance. It shall likewise not apply to fidelity and surety insurance nor to bail bond contracts.

B. The kind and coverage of insurance afforded by any policy shall be determined solely by the coverage specified and established in the provisions of that policy regardless of any name, label, or marketing designation for the policy.

Added by Acts 1970, No. 81, §1; Acts 1989, No. 618, §1; Acts 1989, No. 620, §1; Acts 1990, No. 101, §1.

§1378. Construction

This Part shall be liberally construed to effect the purpose under section R.S. 22:1376, which shall constitute an aid and guide to interpretation.

Added by Acts 1970, No. 81, §1.

§1379. Definitions

As used in this Part:

(1) "Association" means the Insurance Guaranty Association created under R.S. 22:1380.

(2) "Commissioner" means the commissioner of insurance of this state.

(3)(a) "Covered claim" means an unpaid claim, including one for unearned premiums by or against the insured or agent, which arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this Part applies issued by an insurer, if such insurer becomes an insolvent insurer after September 1, 1970, and:

(i) The claimant or insured is a resident of this state at the time of the insured event; or

(ii) The property from which the claim arises is permanently located in this state.

(b) "Covered claim" shall not include any amount due any reinsurer, insurer, health maintenance organization or plan, preferred provider organization or plan, employee retirement fund including but not limited to plans subject to the Employee Retirement Income Security Act of 1974, Medicare, Medicaid, any insurance pool, or any underwriting association, or within the coverage represented, replaced, or both by a certificate of self-insurance as subrogation recoveries or otherwise. In addition, the insured of an insolvent insurer shall likewise not be liable for any subrogation claim asserted by any reinsurer, insurer, health maintenance organization or plan, preferred provider organization or plan, employee retirement fund including but not limited to plans subject to the Employee Retirement Income Security Act of 1974, Medicare, Medicaid, any insurance pool, or any underwriting association or within the coverage represented, replaced, or both by a certificate of self-insurance to the extent of the applicable liability limits previously provided to such insured by the insolvent insurer.

(c) "Covered claim" shall not include any amount due under or arising from a bail bond contract.

(d) "Covered claim" shall not include any claim based on or arising from a pre-insolvency obligation of an insolvent insurer, including but not limited to contractual attorneys' fees and expenses, statutory penalties and attorneys' fees, court costs, interest and bond premiums, or any other expenses incurred prior to the determination of insolvency.

(e) Notwithstanding any other provision of this Part, a "covered daim" shall not include a claim filed with the association after the earlier of five years after the date of the order of liquidation of the insolvent insurer or the final date set by the domiciliary court for the filing of claims against the liquidator or receiver of an insolvent insurer. A "covered claim" shall also not include any claim filed with the association or a liquidator for incurred-but-not-reported losses or unspecified potential losses.

(f) "Covered claim" shall not include any claim asserted for coverage under a policy held by any insured whose net worth exceeds twenty-five million dollars on December thirty-first of the year immediately preceding the date of the determination of the insolvency of the insurer. However, an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis. An "affiliate" of the insured includes any person or entity who directly, or indirectly through one or more intermediaries, controls or is controlled by or is under common control with the insured. "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of the controlled person or entity, whether through the ownership of voting securities, by contract, or otherwise. The consolidated net worth of the insured and all of its subsidiaries and affiliates shall be calculated on the basis of their fair market values. The failure or refusal of a person or entity to return a net worth affidavit to the association after two requests therefor shall create a rebuttable presumption that the noncompliant person or entity had a net worth in excess of twenty-five million dollars on December thirty-first of the year immediately preceding the date of the determination of the insolvency of the insurer. An insured for the purposes of this provision shall not include any state or local governmental agency or subdivision thereof.

(4)(a) "Insolvent insurer" means:

(i) An insurer authorized to transact insurance in this state either at the time the policy was issued or when the insured event occurred, and

(ii) Against whom an order of liquidation with a finding of insolvency has been entered by a final judgment of a court of competent jurisdiction in the insurer's state of domicile or of this state, and which order of liquidation has not been stayed or been the subject of a perfected suspensive appeal or other comparable order.

(b) Any person, and any attorney who represents a person, who files a petition against the association alleging as a basis for the claim the insolvency of an insurer, where said insurer is not an insolvent insurer within the meaning of R.S. 22:1379(4)(a), shall pay the reasonable expenses incurred because of the filing of the petition, including a reasonable attorney's fee, subject to the following conditions:

(i) The association shall furnish to either the person or his attorney, by ordinary service of process, hand delivery, or certified mail, return receipt requested, written notification that the insurer is not an insolvent insurer within the meaning of R.S. 22:1379(4)(a); and

(ii) If, within sixty days of the receipt of such notification, the person or his attorney has not dismissed the petition, with prejudice and at plaintiff's cost.

(5) "Member insurer" means any person who:

(a) Is licensed and authorized to transact insurance in this state, and

(b) Since September 1, 1970, has written at least one policy of insurance to which this Part applies.

(6) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this Part applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. Net direct written premiums does not include premiums on contracts between insurers or reinsurers. Notwithstanding any law to the contrary, no assuming reinsurer shall be required to pay or otherwise contribute to any fund or assessment of the association except for any insurance which the reinsurer directly writes in the state.

(7) "Person" means any individual, company, insurer, association, organization, reciprocal or inter-insurance exchange, partnership, business, trust or corporation.

(8) "Insurance policy" means an insurance contract as defined in R.S. 22:624, and shall not include an agreement whereby an insurer agrees to assume and carry out directly with the policyholder any of the policy obligations of another insurer, such as cut-through endorsements, reinsurance endorsements, facultative reinsurance agreements, treaty reinsurance agreements, and other such agreements, when either insurer is affiliated with the other. "Affiliated" as used in this Section means that either insurer owns or controls, directly or indirectly, a majority of the voting shares of the other or the controlling interest therein, or that both insurers are so owned or controlled by another.

(9) "Ocean marine insurance" includes marine insurance as defined in R.S. 22:6(13), except for inland marine, as well as any other form of insurance, regardless of the name, label, or marketing designation of the insurance policy, which insures against maritime perils or risks and other related perils or risks, which are usually insured against by traditional marine insurances such as hull and machinery, marine builders' risks, and marine protection and indemnity. Such perils and risks insured against include without limitation loss, damage or expense or legal liability of the insured for loss, damage, or expense arising out of or incident to ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness or death or for loss of or damage to the property of the insured or another person, except this definition shall not include insurance on vessels under five tons gross weight.

Added by Acts 1970, No. 81, §1. Amended by Acts 1980, No. 486, §1; Acts 1987, No. 172, §1, eff. June 19, 1987; Acts 1989, No. 620, §1; Acts 1989, No. 688, §1; Acts 1990, No. 105, §1; Acts 1990, No. 129, §1; Acts 1990, No. 254, §1; Acts 1992, No. 835, §1; Acts 1997, No. 1340, §1, eff. July 15, 1997; Acts 1999, Nos. 475, 476, 477, §§1; Acts 2004, No. 109, §1.

§1380. Creation of the association

A. There is created a private nonprofit unincorporated legal entity to be known as the "Insurance Guaranty Association", whose domicile for purpose of suit shall be East Baton Rouge Parish, Louisiana. All insurers defined as member insurers in R.S. 22:1379 shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under a plan of operation established and approved under R.S. 22:1383 and shall exercise its powers through a board of directors established under R.S. 22:1381.

B. The association is not and may not be deemed a department, unit, agency, or instrumentality of the state for any purpose. All debts, claims, obligations, and liabilities of the association, whenever incurred, shall be the debts, claims, obligations, and liabilities of the association only and not of the state, its agencies, instrumentalities, officers, or employees. Association monies may not be considered part of the general fund of the state. The state may not budget for or provide general fund appropriations to the association, and the debts, claims, obligations, and liabilities of the association may not be considered to be a debt of the state or a pledge of its credit.

C.(1) Notwithstanding the provisions of Subsections (A) and (B) of this Section, and except as provided by Paragraph (2) of this Subsection, the association shall be subject to R.S. 42:4.1 through 13 and to R.S. 44:1 through 41, and may be considered as if it were a public body for the purpose of those provisions.

(2) The association may hold an executive session pursuant to R.S. 42:6 for discussion of one or more of the following, and R.S. 44:1 through 41 shall not apply to any documents as enumerated in R.S. 44:1(A)(2) which relate to one or more of the following:

(a) A request by the association for an examination of a member insurer pursuant to R.S. 22:1387(2), provided that such request shall be made known to the attorney general contemporaneous with the action being taken.

(b) Reports and recommendations made by the association to the commissioner pursuant to R.S. 22:1387(4) on any matter relevant to the solvency, liquidation, rehabilitation, or conservation of any member insurer, until such insolvency has been declared or the member insurer has been placed in liquidation, rehabilitation, or conservation.

(c) Matters protected by attorney-client privilege.

(d) Matters with respect to claims or claim files, except documents contained in those files which are otherwise deemed public records.

(e) Prospective litigation against the association after formal written demand, prospective litigation by the association after referral to counsel for review, or pending litigation by or against the association.

(f) Any other matters now provided for or as may be provided for by the legislature.

(g) Discussion by or documents in the custody or control of any committee or subcommittee of the association, or any member or agent thereof, or the board of directors or any member or agent thereof, provided such discussion or documents would otherwise be protected from disclosure by any of the exceptions provided in this Paragraph.

Added by Acts 1980, No. 81, §1. Acts 1990, No. 968, §1; eff. July 25, 1990.

{{**NOTE:** SEE ACTS 1990, NO. 968, §2 FOR PROSPECTIVE APPLICATION PROVISIONS.}}

§1381. Board of directors

A.(1) The board of directors of the association shall consist of nine persons serving terms as established in the plan of operation. The board shall be composed of two consumer representatives appointed by the commissioner, one person appointed by the president of the Senate, one person appointed by the speaker of the House of Representatives, all of whom shall be residents of the state of Louisiana, and five additional persons selected by member insurers, one of which shall be a representative selected by the membership of the Louisiana Association of Fire and Casualty Companies (LAFAC), subject to the approval of the commissioner. Vacancies in the positions for which persons are selected by member insurers shall be filled until the next regularly scheduled election for a member of the board by a majority vote of the remaining members, subject to the approval of the commissioner. At the next regularly scheduled election for a member of the board, the member insurers shall select a member to serve the remainder of the unexpired term of any member appointed by the board, subject to the approval of the commissioner. No person shall serve as a member after his replacement has been either appointed or selected by member insurers and approved by the commissioner. The commissioner shall transmit to the board his approval or disapproval of new board members within thirty days after he has been notified of their selection, and he shall accompany any disapproval of a board member with his written reasons for such disapproval.

(2) The board of directors of the association is hereby abolished and reestablished. The terms of the members of the board of directors serving on the effective date of this Subsection shall terminate on the effective date of this Subsection. The members of the new board of directors shall be selected as provided in this Subsection.

B. In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.

C. Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors.

Added by Acts 1970, No. 81, §1; Acts 1989, No. 619, §1; Acts 1990, No. 129, §1; Acts 1993, No. 397, §1, eff. June 2, 1993; Acts 1997, No. 468, §1, eff. June 26, 1997.

NOTE: SEE ACTS 1997, NO. 468, §§2, 3, FOR APPLICABILITY.

§1382. Powers and duties of the association

A. The association shall:

(1)(a) Be obliged to the extent of the covered claims existing prior to the determination of the insurer's insolvency, or upon order of the court as provided in R.S. 22:735, or arising after such determination but prior to the first to occur of the following events:

(i) Expiration of thirty days after the date of such determination of insolvency,

(ii) Expiration of the policy, or

(iii) Replacement or cancellation of the policy at the instance of the insured if he does so within thirty days of the determination, but such obligation shall include only that amount of each covered claim, except return premiums, which is in excess of one hundred dollars and is less than one hundred fifty thousand dollars, per claim, subject to a maximum limit of three hundred thousand dollars per accident or occurrence, nor shall a claim for the portion of unearned premiums in excess of ten thousand dollars be allowed.

(b) The applicable limit per claim and per accident or occurrence shall be exhaustive of the entire liability of the association under this Part, however arising, without regard to the nature of or basis for that liability, except court costs incurred subsequent to the date of insolvency.

(c) Excepting claims for unearned premiums, which shall be subject to the ten thousand dollar limitation provided herein, the association shall pay the full amount of any covered claim arising out of a worker's compensation policy.

(d) In no event shall the association be obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises.

(e) "Accident or occurrence" in this Section means one proximate, uninterrupted, or continuing cause which results in all of the injuries or damages even though several discrete items of damage result, and even though multiple claims and claimants may arise as a result of one such accident or occurrence. A series of claims arising from the same accident or occurrence shall be treated as due to that one accident or occurrence and thus shall be subject to the aggregate liability limit established herein.

(2) Be deemed the insurer to the extent of its obligation on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent; however, when the liability of the association under this Part has been exhausted by payment, the obligation of the association to provide a defense to the insured of an insolvent insurer shall cease.

(3)(a)(i) Assess insurers amounts necessary to pay the obligations of the association under Paragraph A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and the cost of examinations under R.S. 22:1388, to fund loans or provide guarantees to member insurers under rehabilitation or liquidation and other expenses authorized by this Part. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year, whether or not a company withdraws subsequent to the preceding calendar year, bears to the net direct written premiums of all member insurers for the preceding calendar year. Each member insurer shall be notified of the assessment not later than thirty days before it is due.

(ii)(aa) Beginning January 1, 1990, and ending December 31, 2002, no member insurer may be assessed in any year an amount greater than two percent of that member insurer's net direct written premiums for the preceding calendar year. Beginning January 1, 2003, and thereafter, no member insurer may be assessed in any year an amount greater than one percent of that member insurer's net direct written premiums for the preceding calendar year. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. However, as to any assessment or portion thereof payable after May 1, 1992, payors doing business in Louisiana under a valid certificate of authority as of January 1, 1992, and who as of August 21, 1992 have at least one-half of their total admitted assets invested in qualifying Louisiana investments as defined in R.S. 22:1068(C), shall receive an earned credit for the amount of such assessment payable as follows: the association shall establish on its books an assessment credit fund and shall set aside and escrow in such fund ninety-five percent of the amount actually received by the association from each payor qualifying for such earned credit; not later than sixty days after receipt of such payments, the association shall certify to each payor the amount in such fund attributable to each qualifying payor; amounts credited to the assessment credit fund shall be expended by the association, only to the extent funds are not otherwise available, to meet its obligations under any cooperative endeavor agreement dated as of October 1, 1990, (together with all amendments and supplements thereto entered into by the association) and upon satisfaction of all of the association's obligations under such cooperative endeavor agreement and the termination thereof in accordance with its terms, the balances in the assessment credit fund shall be promptly paid over by the association to each payor qualifying for the earned credit in the amounts certified by the association; to the extent amounts then on deposit in the fund are insufficient to make such payments to such payors, such amounts shall be paid over by the association pro rata. However, the payors shall continue to have a claim of first priority against funds thereafter received by the association until the earned credits are paid in full by the association. Notwithstanding the foregoing, no amounts shall be paid by the association to any payor that has received an earned credit until the association has satisfied all of its obligations under any cooperative endeavor agreement, dated as of October 1, 1990, (together with all amendments and supplements thereto entered into by the association) and such agreement has been terminated in accordance with its terms. In the event any indebtedness secured or permitted to be secured under the cooperative endeavor agreement dated as of October 1, 1990, (together with all amendments and supplements thereto) is refunded or otherwise refinanced by the extension of such existing cooperative endeavor agreement and the incurrence by the association thereunder of indebtedness not contemplated by such agreement as of August 21, 1992, upon the payment and satisfaction by the association of all of its obligations and commitments thereunder, such agreement shall be deemed to be terminated for purposes of this Item.

(bb) As to any assessment made on or after the termination of any such cooperative endeavor agreement in accordance with its terms or deemed terminated under the provisions of this Item, payors doing business in Louisiana under a valid certificate of authority as of January 1, 1992, and who, on August 21, 1992, have at least one-half of their admitted assets invested in qualifying Louisiana investments as defined in R.S. 22:1068(C), shall have such assessment reduced by eighty percent of the amount otherwise assessed.

(iii) The association may exempt or defer, in whole or in part, the assessment of any member insurer if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. Each member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer.

(iv) Beginning January 1, 1990, the amount of the assessment shall be offset, in the same manner that an offset is provided against the premium tax liability in Paragraph (A)(3)(c) of this Section, against the assessment levied by R.S. 22:1419, provided that such offset shall not be applied against any portion of the assessments to be deposited to the credit of the Municipal Police Employees' Retirement System, the Sheriffs' Pension and Relief Fund, and the Firefighters' Retirement System. To qualify for this offset, the payer shall file a sworn statement with the annual report required by Part XXIII of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950 showing as of December thirty-first of the reporting period that at least the following amounts of the total admitted assets of the payer, less assets in an amount equal to the reserves on its policies issued in foreign countries in which it is authorized to do business and which countries require an investment therein as a condition of doing business, are invested and maintained in qualifying Louisiana investments as defined in R.S. 22:1068(C). If one-sixth of the total admitted assets of the payer are in qualifying Louisiana investments, then the offset shall be sixty-six and two-thirds percent of the amount otherwise assessed; if at least one-fifth of the total admitted assets of the payer are in qualifying Louisiana investments, then the offset shall be seventy-five percent of the amount otherwise assessed; if at least one-fourth of the total admitted assets of the payer are in qualifying Louisiana investments, the offset shall be eighty-five percent of the amount otherwise assessed; and if at least one-third of the total admitted assets of the payer are in qualifying Louisiana investments, then the offset shall be ninety-five percent of the amount otherwise assessed. If the total of the net premium tax liability and the assessment for the expenses of the Louisiana Insurance Rating Commission paid for the previous year was less than the offset allowed under R.S. 22:1382(A)(3)(c) for the previous year, the member company may reduce its assessment payment to the Louisiana Insurance Guaranty Association for the current year by that difference.

(v) An insurer may transfer up to twenty percent annually of any offset as described in this Section with the prior approval of the commissioner to an affiliated insurer. For the purposes of this Section:

(aa) "Affiliated insurer" means an insurance company licensed or holding a certificate of authority to do business in this state which controls, is controlled by, or is under common control with, another insurer.

(bb) "Control" means holding, directly or indirectly, the ownership of or power to vote, at least eighty percent of the voting stock of another member insurer.

(b) The association shall issue to each insurer paying an assessment under this Act a certificate of contribution, in a form prescribed by the commissioner, for the amount so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue.

(c) A certificate of contribution issued to a member company shall be offset against its premium tax liability in an amount not to exceed ten percent of the assessment for the year of assessment and not to exceed ten percent of the assessment per year for each succeeding year, not to exceed a total offset of one hundred percent for each assessment. During the calendar year of issuance of a certificate of contribution, and yearly thereafter, a member shall at its option have the right to show a certificate of contribution as an asset in the form approved by the commissioner at percentages of the original face amount approved by the commissioner, equal to the unused offset as of each such calendar year.

(d) REPEALED BY ACTS 2004, No. 140, §1.

(e) To the extent amounts have been written off under R.S. 22:1382(A)(3)(c) above, the provisions of R.S. 22:1390 shall not apply.

(f) Not subject the premium dollars paid to an insurer by any insured whose net worth exceeds twenty-five million dollars on December thirty-first to the assessment provided for in this Section for the next calendar year. An insured's net worth shall include the aggregate net worth of the insured and all of its subsidiaries and affiliates calculated on a consolidated basis. An "affiliate" of the insured includes any person or entity who directly, or indirectly through one or more intermediaries, controls or is controlled by or is under common control with the insured. "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of the controlled person or entity, whether through the ownership of voting securities, by contract, or otherwise. The consolidated net worth of the insured and all of its subsidiaries and affiliates shall be calculated on the basis of their fair market values. Any insurer deducting the premium dollars from its assessment shall provide a net worth affidavit to the association from each insured whose premium dollars are being deducted together with a statement of the amount of premium dollars paid by such insured in accordance with procedures established by the association.

(4) Investigate claims brought against the association and adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims. On contradictory motion of the association, a court of proper jurisdiction and venue over the claim shall enter a formal order annulling any unsatisfied preinsolvency settlement, release, or consent judgment entered into by the insolvent insurer in its name or the name of the insured, upon a showing of fraud, ill practice, or where the settlement is clearly excessive, considering all relevant factors, including but not limited to coverage, liability, and quantum issues.

(5) Notify such persons as the commissioner directs under R.S. 22:1384(B)(1).

(6) Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner, but such designation may be declined by a member insurer.

(7) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this Part.

(8) Annually submit the plan of operation to the commissioner of insurance in accordance with the provisions of R.S. 22:1383 and of this Part. Approval by the commissioner shall not be unreasonably withheld. If the plan of operation is disapproved in whole or in part, the commissioner shall provide written reasons as to each disapproved part, and the association shall resubmit the part of the plan which has been disapproved by the commissioner within thirty days thereafter. The preceding plan of operation shall remain in effect until such time as the revised plan is effective. Amendments to the plan of operation shall be submitted to the commissioner for approval within ten days of adoption by the association, and approval of amendments shall be in accordance with R.S. 22:1383 and with this Part except as otherwise provided in this Section.

(9) Annually promulgate policies and procedures which shall be incorporated into the plan of operation, which policies and procedures are designed to increase participation for minorities and women in contractual legal services entered into by such association.

(10) Annually promulgate policies and procedures relative to the appointment of all legal counsel which shall be incorporated into the plan of operation.

(11) Annually promulgate policies and procedures relative to a system of alternative dispute resolution of lawsuits and claims which shall be incorporated into the plan of operation, and implement such a system of alternative dispute resolution.

(12) Coordinate and work in conjunction with a special deputy commissioner designated and appointed by the commissioner of insurance, said deputy commissioner being charged with oversight and implementation of the provisions of this Part.

B. The association may:

(1) Employ or retain such persons as are necessary to handle claims and perform other duties of the association.

(2) Borrow funds necessary to effect the purposes of this Part. In connection therewith the association may agree to such terms and conditions as it deems necessary and proper, and the association may assign to the state or any agency or authority thereof, or to any private entity, the right to the receipt of assessments to the extent necessary to provide for the payment of bonds issued by the state or such agency or authority, or such private agency, for the purpose of providing for the repayment of such borrowings.

(3) Sue or be sued. The power to sue includes the power and right to intervene as a party before any court in this state that has jurisdiction over an insolvent insurer.

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this Part.

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this Part.

(6) Refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities, if, at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

(7) As to any member insurer under rehabilitation or liquidation, and pursuant to a written plan of full or partial rehabilitation or liquidation jointly submitted by the commissioner through his counsel of record, which counsel is approved by the attorney general pursuant to the provisions of this Code, and the Louisiana Insurance Guaranty Association through its counsel of record, and subject to approval of the court in which such rehabilitation or liquidation proceeding is pending, which court must be satisfied that such plan is the most cost-effective method of dealing with the conditions creating the member insurer's impairment or insolvency, and improving the condition and is in the best interest of the member insurer's policyholders; and is in the best interests of the association, then the association may:

(a) Guarantee or assume, or cause to be guaranteed or assumed, any or all of the policies, contracts, or other obligations of such member insurer.

(b) Provide such monies, pledges, notes, guarantees, or other means as are proper to effectuate R.S. 22:1382(B)(7)(a), and to assume payment of the obligations of such member insurer pending action under R.S. 22:1382(B)(7)(a).

(c) Loan money to such member insurer.

C.(1) Notwithstanding any other provision to the contrary and unless such other law is specifically excepted from this Section, the provisions of this Section shall supersede and prevail over any other law to the contrary.

(2) This Section shall not apply to R.S. 24:38(C) and 654.

D. In the event that the association pays a claim on behalf of an insured whose net worth exceeds twenty-five million dollars on December thirty-first of the year immediately preceding the date of the determination of the insolvency of the insurer, the association shall have the right to recover from the insured all costs incurred in the defense of said claim, including attorney fees, administrative costs, court costs, indemnity, settlement, or other defense costs. An insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis, as provided in R.S. 22:1379(3)(f). An insured for the purposes of this provision shall not include any state or local governmental agency or subdivision thereof.

Added by Acts 1970, No. 81, §1. Amended by Acts 1975, No. 234, §1; Acts 1985, No. 780, §1, eff. Sept. 1, 1985; Acts 1987, No. 172, §1, eff. June 19, 1987; Acts 1989, No. 685, §1; Acts 1990, No. 1, §1; eff. May 1, 1990; Acts 1990, No. 253, §1; Acts 1991, No. 941, §1, eff. July 24, 1991; Acts 1992, No. 237, §1, eff. June 10, 1992; Acts 1992, No. 500, §1; Acts 1992, No. 517, §1, eff. June 25, 1992; Acts 1993, No. 397, §2, eff. June 2, 1993; Acts 1993, No. 955, §1; Acts 1999, Nos. 475, 1327, 77, §§1; Acts 2004, No. 109, §1; Acts 2004, No. 140, §1.

§1383. Plan of operation

A.(1) The association shall submit to the commissioner and the Senate Committee on Insurance and the House Committee on Insurance a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the commissioner; however, beginning on August 15, 1993, prior to the implementation of any new plan or any amendment to such new plan or an existing plan of operation, the Senate Committee on Insurance and the House Committee on Insurance may hold a hearing on such new plan or any amendments to a new or existing plan of operation. After a hearing, if any, the respective legislative committees shall either approve or reject the plan or amendment as presented. No plan or amendment shall be implemented if it was rejected by a legislative committee. If a hearing is not held within thirty days after receipt of the plan or amendment by such committees, then the plan or amendment may be implemented as approved by the commissioner.

(2) If the association fails to submit a suitable plan of operation within ninety days following September 1, 1970, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Part. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner. All rules and regulations promulgated by the commissioner under the provisions of this Paragraph shall have no effect until they are reviewed and approved by the Senate Committee on Insurance and the House Committee on Insurance.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall:

(1) Establish the procedures whereby all the powers and duties of the association under R.S. 22:1382 will be performed.

(2) Establish procedures for handling assets of the association.

(3) Establish the amount and method of reimbursing the members of the board of directors under R.S. 22:1381.

(4) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of such claims shall be periodically submitted to the association or similar organization in another state by the receiver or liquidator.

(5) Establish regular places and times for meetings of the board of directors.

(6) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors. All such records shall be subject to review by the Senate Committee on Insurance and/or the House Committee on Insurance upon written request of the respective legislative chairman.

(7) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty days after the action or decision.

(8) Establish the procedures whereby selections for the board of directors will be submitted to the commissioner.

(9) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

D. The plan of operation may provide that any or all powers and duties of the association, except those under R.S. 22:1382(A)(3) and R.S. 22:1382(B)(2) are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Such a corporation, association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorably and effective than that provided by this Part.

Added by Acts 1970, No. 81, §1; Acts 1993, No. 397, §2, eff. June 2, 1993.

§1384. Duties and powers of the commissioner

A. The commissioner shall:

(1) Notify the association of the existence of an insolvent insurer not later than three days after he receives notice of the determination of the insolvency.

(2) Upon request of the board of directors, provide the association with a statement of the net direct written premiums of each member insurer.

(3) Consult with the board of directors of the association, or with said board's duly appointed committee, on all applications to do business in this state made by domestic and foreign insurers which are prospective member insurers and all applications for modification of existing certificates of authority to do business in this state made by such insurers, to determine whether such insurer is in such a condition that its transaction of business in this state would be hazardous to policyholders and creditors in this state and to the public, or that its transaction of business in this state or the modification of its present authority to transact business in this state would involve a substantial risk of a covered claim being made against the association under the provisions of this Part. In the event the association or such board's duly appointed committee recommends in writing to the commissioner that a domestic or foreign insurer not be admitted to do business in this state or that the existing certificate of authority issued to such an insurer not be modified because one or more of the above cited conditions are deemed to exist, then in that event it shall be the duty of the commissioner to conduct a hearing on the application, giving the insurer at least thirty days notice of such hearing. The hearing shall be conducted in accordance with the Rules of Practice and Procedure before the commissioner of insurance and the Administrative Procedure Act of Title 22 of the Louisiana Revised Statutes of 1950. The association shall be notified of the hearing at least fifteen days in advance thereof, and shall be afforded a reasonable opportunity to inspect all documentary evidence, to present evidence and examine witnesses if it so elects. Within thirty days after the termination of the hearing, the commissioner shall make his order thereon which shall in all respects comply with the provisions of R.S. 22:1359.

B. The commissioner may:

(1) Require that the association notify the insureds of the insolvent insurer and any other interested parties of the determination of insolvency and of their rights under this Part. Such notification shall be by mail at their last known address, where available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation shall be sufficient.

(2) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on any member insurer which fails to pay an assessment when due. Such fine shall not exceed five percent of the unpaid assessment per month, except that no fine shall be less than one hundred dollars per month.

(3) Revoke the designation of any servicing facility if he finds claims are being handled unsatisfactorily.

Added by Acts 1970, No. 81, §1. Amended by Acts 1976, No. 219, §1; Acts 1979, No. 474, §1.

§1385. Effect of paid claims

A. Any person recovering under this Part shall be deemed to have assigned his rights under the policy to the association to the extent of his recovery from the association. Every insured or claimant seeking the protection of this Part shall cooperate with the association to the same extent as such person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of insureds to the receiver, liquidator or statutory successor for unpaid assessments.

B. The receiver, liquidator or statutory successor of an insolvent insurer shall be bound by settlements of covered claims by the association or a similar organization in another state. The court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this Part against the assets of the insolvent insurer. The expenses of the association or similar organization in handling claims shall be accorded the same priority as the liquidator's expenses.

C. The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

Added by Acts 1970, No. 81, §1.

§1386. Nonduplication of recovery

A. Any person having a claim against an insurer under any provision in an insurance policy, other than a policy of an insolvent insurer which is also a covered claim, shall be required first to exhaust his rights under such policy. Such other policies of insurance shall include but shall not be limited to liability coverage, uninsured or underinsured motorist liability coverage, or both, hospitalization, coverage under self-insurance certificates, coverage under a health maintenance organization or plan, preferred provider organization or plan, or similar plan, and any and all other medical expense coverage. All entities that are prohibited from recovering against the association, as specified in R.S. 22:1379(3)(b), shall also be considered insurers for purposes of this Subsection. As to the association, any amount payable by such other insurance shall act as a credit against the damages of the claimant, and the association shall not be liable for such portion of the damages of the claimant. In the case of a claimant alleging personal injury or death caused by exposure to asbestos fibers or other claim resulting from exposure to, release of, or contamination from any environmental pollutant or contaminant, such claimant must first exhaust any and all other insurance available to the insured for said claim for any policy period for which insurance is available before recovering from the association, even if an insolvent insurer provided the only coverage for one or more policy periods of the alleged exposure.

B. Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured except that if it is a first party claim for damage to property with a permanent location, he shall seek recovery first from the association of the location of the property, and if it is a workers' compensation claim, he shall seek recovery first from the association of the residence of the claimant. A claimant alleging personal injury or death caused by exposure to asbestos fibers or other claim resulting from exposure to, release of, or contamination from any environmental pollutant or contaminant, asserted against the association must either be a domiciliary of the state of Louisiana at the time of the exposure or allege that his exposure to asbestos or other environmental hazard, which is a substantial contributing factor to the physical impairment upon which the claim is based, occurred in Louisiana. Where more than one claimant is joined, each claimant must independently establish that Louisiana is either his domicile or place in which the alleged exposure occurred.

C. Any recovery under this Part by any claimant not a resident of the state of Louisiana at the time such claim arose, shall not exceed the lesser of the recovery allowed under this Part or that payable by the insurance guaranty association or its equivalent in the claimant's state of residence. As to the association, any amount payable by the other guaranty association or its equivalent shall act as a credit against the damages of the claimant, and the association shall not be liable for that portion of the damages of the claimant.

D. The association shall have no duty to provide a separate defense at its cost to an insured of an insolvent insurer as to any issue arising out of the coverage of this Section.

Added by Acts 1970, No. 81, §1. Acts 1983, 1st Ex. Sess., No. 1, §6; Acts 1990, No. 130, §1; Acts 1992, No. 237, §2, eff. June 10, 1992; Acts 1999, No. 477, §1; Acts 2004, No. 108, §1.

{{**NOTE:** SEE ACTS 1992, NO. 237, §3 FOR PROVISION ON APPLICABILITY TO PENDING CLAIMS.}}

§1387. Prevention of insolvencies

To aid in the detection and prevention of insurer insolvencies:

(1) It shall be the duty of the board of directors, upon majority vote, to notify the commissioner of any information indicating any member insurer may be insolvent or in a financial condition hazardous to the policyholders or the public.

(2) The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be in a financial condition hazardous to the policyholders or the public. Within thirty days of the receipt of such request, the commissioner shall begin such examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the commissioner designates. The cost of such examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from complying with Subsection (3). The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner but it shall not be open to public inspection prior to the release of the examination report to the public.

(3) It shall be the duty of the commissioner to report to the board of directors when he has reasonable cause to believe that any member insurer examined or being examined at the request of the board of directors may be insolvent or in a financial condition hazardous to the policyholders or the public.

(4) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer. Such reports and recommendations shall not be considered public documents.

(5) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(6) The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report on the history and causes of such insolvency, based on the information available to the association, and submit such report to the commissioner.

Added by Acts 1970, No. 81, §1.

§1388. Examination of the association

The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit, not later than March thirtieth of each year, a financial report for the preceding calendar year in a form approved by the commissioner. The form established by the commissioner shall determine the association's accounting method and basis of financial reporting for all purposes.

Added by Acts 1970, No. 81, §1; Acts 1997, No. 468, §1, eff. June 26, 1997.

§1389. Tax exemption

The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions except taxes levied on real or personal property.

Added by Acts 1970, No. 81, §1.

§1390. Recognition of assessments in rates

The rates and premiums charged for insurance policies to which this Part applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association and such rates shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments paid by the member insurer.

Added by Acts 1970, No. 81, §1.

§1391. Immunity

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the association or its agents or employees, the board of directors, or the commissioner or his representatives for any action taken by them in the performance of their powers and duties under this Part.

Added by Acts 1970, No. 81, §1.

§1392. Stay of proceedings; reopening of default judgments; execution of judgments; proration

A. All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this state shall be stayed for ninety days from the date the insolvency is determined to permit proper defense by the association of all pending causes of action. In addition, on ex parte motion or application by the association and for good cause shown, the court having jurisdiction over the proceedings incident to the liquidation of the insolvent insurer may extend that stay order for an additional ninety days.

B. As to any covered claims arising from a judgment under any decision, verdict, or finding based on the default of the insolvent insurer or its failure to defend an insured, the association either on its own behalf or on behalf of such insured may apply to have such judgment, order, decision, verdict, or finding set aside by the same court or administrator that made such judgment, order, decision, verdict, or finding and shall be permitted to defend against such claim on the merits.

C. In addition to any other requirement imposed by law, no judgment creditor shall attempt the execution of any judgment against the association without providing prior notice of its intent to do so. As a prerequisite of the execution of judgment, the executive director of the association or the chairman of the board of directors of the association shall be notified by certified mail, return receipt requested, not less than fifteen days prior to the execution of the judgment.

D. Any proration pursuant to R.S. 22:1382(A)(3)(a)(ii) shall apply to all covered claims existing as of the date the proration becomes effective, as well as the covered claims arising subsequently, including but not limited to settlements, agreements, consent judgments, and other judgments.

Added by Acts 1970, No. 81, §1. Acts 1990, No. 102, §1; Acts 1991, No. 222, §1, eff. July 2, 1991.

§1393. Advertisements

A. Advertisements which include a reference to the coverage or protection by the Insurance Guaranty Association are specifically prohibited.

B. As used in this Section, "advertisements" means any communication by print, television, radio, or other means for mass distribution of information.

C.(1) Whoever violates this Section shall, upon conviction, be fined not less than five hundred dollars nor more than one thousand dollars for a first offense, and not less than one thousand dollars nor more than two thousand dollars for a second offense.

(2) Conviction for violations of this Section as a second offense shall be grounds for suspension or revocation of the license of the violator by the commissioner.

Added by Acts 1970, No. 81, §1. Acts 1990, No. 260, §1.

§1394. Effective date

The provisions of this Part shall become effective on September 1, 1970.

Added by Acts 1970, No. 81, §1.

PART XXIX-B. LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

§1395.1. Title

This Part shall be known and may be cited as the "Louisiana Life and Health Insurance Guaranty Association Act".

Acts 1991, No. 998, §1, eff. Sept. 30, 1991.

§1395.2. Purpose

A. The purpose of this Part is to protect, subject to certain limitations, the persons listed in R.S. 22:1395.3(A) against failure in the performance of contractual obligations, under life and health insurance policies and annuity contracts specified in R.S. 22:1395.3(B), because of the impairment or insolvency of the member insurer that issued the policies or contracts.

B. To provide this protection, an association of insurers is hereby created to pay benefits and to continue coverages as limited herein. Members of the association are subject to assessment to provide funds to carry out the purpose of this Part.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991.

§1395.3. Coverages and limitations

A. This Part shall provide coverage for the policies and contracts specified in Subsection B of this Section:

(1) To any person who, regardless of residence, except for a nonresident certificate holder under a group policy or contract, is the beneficiary, assignee, or payee of a person covered under Paragraph (2) of this Subsection.

(2) To any person who is the owner of or certificate holder under such a policy or contract, and who:

(a) Is a resident; or

(b) Is not a resident, but only if all of the following conditions are satisfied:

(i) The insurer which issued such policy or contract is domiciled in this state.

(ii) The insurer has never held a license or certificate of authority in the state in which such person resides.

(iii) Such state has an association similar to the association created by this Part.

(iv) The person is not eligible for coverage by such association.

B.(1) This Part shall provide coverage to the persons specified in Subsection A of this Section for direct nongroup life, health, annuity and supplemental policies or contracts, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this Part.

(2) This Part shall not provide coverage for:

(a) Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract holder.

(b) Any policy or contract of reinsurance, unless assumption certificates have been issued.

(c) Any portion of a policy or contract to the extent that the rate of interest on which it is based:

(i) Averaged over the period of four years prior to the date on which the association becomes obligated with respect to the policy or contract exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contra ct was issued less than four years before the association became obligated.

(ii) On and after the date on which the association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available.

(d) Any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or similar entity under:

(i) A Multiple Employer Welfare Arrangement as defined in 29 U.S.C. Section 514 *(the Employee Retirement Income Security Act of 1974) as amended.

(ii) A minimum premium group insurance plan.

(iii) A stop-loss group insurance plan.

(iv) An administrative services only contract.

(e) Any portion of a policy or contract to the extent that it provides dividends, premium refunds, or experience rating credits, or provides that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of such policy or contract.

(f) Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state.

(g) Any unallocated annuity contract except unallocated annuity contracts and defined contribution government plans qualified under Section 403(b) of the United States Internal Revenue Code (26 U.S.C. 403(b)).

C. The benefits for which the association shall become liable shall in no event exceed the lesser of:

(1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(2) With respect to any one life, regardless of the number of policies or contracts:

(a) Three hundred thousand dollars in life insurance death benefits, but not more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance.

(b) One hundred thousand dollars in health insurance benefits, including any net cash surrender and net cash withdrawal values.

(c) One hundred thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

D. However, in no event shall the association be liable to expend more than three hundred thousand dollars in the aggregate with respect to any one individual under Subsection C.

E. The liability of the association and benefits paid by the association under any valid act of assignment of benefits pursuant to Subsection C of this Section for any claim under a health policy shall be an amount payable under Title XVIII of the Social Security Act, 42 U.S.C. §301 et seq. The board of directors of the association shall establish reasonable amounts for any services or supplies covered under a health policy or contract for which an amount has not been determined under the federal Medicare program. A health care provider, defined in R.S. 40:1299.41, shall not bill any person covered by a health policy or contract for which the association has become liable for the amount of any bill in excess of the amount paid by the association.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991.

*As Appears in the enrolled bill

§1395.4. Definitions

As used in this Part:

(1) "Account" means any of the four accounts created by R.S. 22:1395.5(A).

(2) "Association" means the Louisiana Life and Health Insurance Guaranty Association created by R.S. 22:1395.5.

(3) "Commissioner" means the commissioner of insurance.

(4) "Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof, for which coverage is provided by R.S. 22:1395.3.

(5) "Covered policy" means any policy or contract within the scope of this Part as set forth by R.S. 22:1395.3.

(6) "Impaired insurer" means a member insurer which, after September 30, 1991, is not an insolvent insurer, and

(a) Is deemed by the commissioner to be potentially unable to fulfill its contractual obligations;

(b) Is placed under an order of rehabilitation or conservation by a court of competent jurisdiction; or

(c) In the case of a stock insurer, whose paid-in capital, minimum surplus and operating surplus, or in the case of a mutual insurer, whose minimum surplus and operating surplus does not satisfy the minimum level required by the Louisiana Insurance Code.

(7) "Insolvent insurer" means a member insurer which, after September 30, 1991, is placed under an order by a court of competent jurisdiction with a finding of insolvency.

(8) "Member insurer" means any insurer licensed or which holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided by R.S. 22:1395.3, and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, but shall not include any of the following:

(a) A health maintenance organization.

(b) A fraternal benefit society.

(c) A mandatory state pooling plan.

(d) A mutual assessment company or any entity that operates on an assessment basis.

(e) An insurance exchange.

(f) A nonprofit hospital or medical service organization.

(g) Any entity similar to any of the above.

(9) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(10) "Person" means any individual, corporation, partnership, association, or voluntary organization.

(11) "Premiums" means amounts received on covered policies or contracts, less considerations, deposits, dividends, and experience credits thereon. "Premiums" shall not include any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided by R.S. 22:1395.3(B), except that accessible premiums shall not be reduced on account of R.S. 22:1395.3(B)(2)(c)(ii) relating to interest limitations with respect to any one individual, any one participant, and any one policyholder.

(12) "Resident" means any person who resides in this state at the time an insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business.

(13) "Supplemental contract" means any agreement entered into for the distribution of policy or contract proceeds.

(14) "Unallocated annuity contract" means any annuity contract or group annuity certificate which is not issued to and owned by an individual except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Acts 1994, 3rd Ex. Sess., No. 92, §1.

§1395.5. Creation of the association

A. There is hereby created a nonprofit entity to be known as the Louisiana Life and Health Insurance Guaranty Association whose legal domicile shall be in the parish of East Baton Rouge. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its function under the plan of operation established and approved pursuant to R.S. 22:1395.9 and shall exercise its powers through a board of directors established by R.S. 22:1395.6. For purposes of administration and assessment, the association shall maintain four accounts:

(1) The life insurance account.

(2) The annuity account excluding unallocated annuity contracts and defined contribution government plans qualified under Section 403(b) of the United States Internal Revenue Code (26 U.S.C. Section 403(b)).

(3) The defined contribution plan account, meaning defined contribution plans qualified under Section 403(b) of the United States Internal Revenue Code.

(4) The health insurance account.

B. The association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this state. The commissioner shall be provided any records of the association concerning the operations, budget, and management of the association upon request.

C.(1) Notwithstanding any other provision of law to the contrary, the association is not and may not be deemed a department, unit, agency, instrumentality, commission, or board of the state for any purpose unless specifically set forth herein and shall not be subject to laws governing such departments, units, agencies, instrumentalities, commissions, or boards of the state. All debts, claims, obligations, and liabilities of the association, whenever incurred, shall be the debts, claims, obligations, and liabilities of the association only and not of the state, its agencies, instrumentalities, officers, or employees. The state may not budget for or provide general fund appropriations to the association, and the debts, claims, obligations, and liabilities of the association may not be considered to be a debt of the state or a pledge of its credit. The association shall be subject to the provisions of Title 24 of the Louisiana Revised Statutes of 1950 regarding audits by the legislative auditor. The form established by the commissioner pursuant to R.S. 22:1388 for the financial report shall determine the association's accounting method and basis of financial reporting for all purposes notwithstanding any other provision to the contrary.

(2) Notwithstanding the provisions of Paragraph (1) of this Subsection, and except as provided in Paragraph (3) of this Subsection, the association shall be subject to the provisions of R.S. 44:1 et seq. and R.S. 42:4.1 et seq., and may be considered as if it were a public body for the purposes of this Section.

(3) The association may hold an executive session pursuant to R.S. 42:6 for discussion of one or more of the following, and R.S. 44:1 et seq. shall not apply to any documents as enumerated in R.S. 44:1(A)(2) which relate to one or more of the following:

(a) A request by the association or the commissioner for an examination of a member insurer pursuant to R.S. 22:1395.11.

(b) Reports and recommendations made by the association to the commissioner pursuant to R.S. 22:1395.13 on any matter relevant to the solvency, impairment, liquidation, rehabilitation, or conservation of any member insurer, until such insolvency has been declared or the member insurer has been placed in liquidation, rehabilitation, or conservation.

(c) Matters protected by attorney-client privilege.

(d) Matters with respect to claims or claim files, except documents contained in those files which are otherwise deemed public records.

(e) Prospective litigation against the association after formal written demand, prospective litigation by the association after referral to counsel for review, or pending litigation by or against the association.

(f) Any other matters now provided for or as may be provided for by the legislature.

(g) Discussion by or documents in the custody or control of any committee or subcommittee of the association, or any member or agent thereof, or the board of directors or any member or agent thereof, provided such discussion or documents would otherwise be protected from disclosure by any of the exceptions provided in this Paragraph.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Acts 1992, No. 115, §1; Acts 1997, No. 534, §1, eff. July 3, 1997.

§1395.6. Board of directors

A. The board of directors of the association shall consist of ten member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner from the following groups:

(1) One representative of a member which is a domestic commercial insurance company and a member of the Louisiana Insurers' Conference.

(2) Two representatives of member insurers selected from recommendations of the American Council of Life Insurance Companies.

(3) One representative of a member insurer selected from recommendations of the Health Insurance Association of America.

(4) One representative of a member insurer which is a domestic commercial health insurer.

(5) One representative of a member insurer which is a member of the Life Insurers' Conference.

(6) One representative of a member insurer which is a member of the National Association of Life Companies.

(7) One representative to be approved by the commissioner, who represents a member insurer which is a domestic nonprofit mutual insurer engaged exclusively in the business of furnishing hospital service, medical, or surgical benefits.

(8) Two persons, one appointed by the president of the Senate and one appointed by the speaker of the House of Representatives, both of whom shall be residents of the state of Louisiana.

B. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner. To select the initial board of directors and initially organize the association, the commissioner shall give notice to all insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial members.

C. In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

D. Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors. The members of the board shall not otherwise be compensated by the association for their services.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Acts 1994, 3rd Ex. Sess., No. 92, §1.

§1395.7. Powers and duties of the association

A. If a member insurer is an impaired domestic insurer, the association may, in its discretion, subject to any conditions imposed by the association, take such actions as do not impair the contractual obligations of the impaired insurer, that are approved by the commissioner:

(1) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer.

(2) Provide such monies, pledges, notes, guarantees, or other means as are proper to effectuate R.S. 22:1395.7(A)(1) and assure payment of the contractual obligations of the impaired insurer pending action under R.S. 22:1395.7(A)(1).

(3) Loan money to the impaired insurer.

B.(1) If an insurer is an impaired insurer, whether domestic, foreign, or alien, and the insurer is not paying claims timely, then subject to the preconditions specified in R.S. 22:1395.7(A)(2), the association shall, in its discretion, either:

(a) Take any of the actions specified in R.S. 22:1395.7(A), subject to the conditions therein.

(b) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the association in its plan of operation and approved by the commissioner.

(2) The association shall be subject to the requirements of R.S. 22:1395.7(B)(1) only if:

(a) The laws of its state of domicile of the impaired insurer provide that until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations:

(i) The delinquency proceeding shall not be dismissed.

(ii) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management.

(iii) It shall not be permitted to solicit or accept new business or have any suspended or revoked license restored.

(b)(i) If the impaired insurer is a domestic insurer, it has been placed under an order of rehabilitation by a court of competent jurisdiction in this state.

(ii) If the impaired insurer is a foreign or alien insurer:

(aa) It has been prohibited from soliciting or accepting new business in this state;

(bb) Its certificate of authority has been suspended or revoked in this state; and

(cc) A petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of its state.

C. If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(1)(a) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies or contracts of the insolvent insurer.

(b) Assure payment of the contractual obligations of the insolvent insurer.

(c) Provide such monies, pledges, guarantees, or other means as are reasonably necessary to discharge such duties.

(2) With respect only to life and health insurance policies, provide benefits and coverages in accordance with R.S. 22:1395.7(D).

D. When proceeding under R.S. 22:1395.7(B)(1)(b) or (C)(2), the association shall, with respect to only life and health insurance policies:

(1) Assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies of the insolvent insurer, for claims incurred.

(a) With respect to group policies, not later than the succeeding next renewal date under such policies or contracts or forty-five days, but in no event less than thirty days, after the date on which the association becomes obligated with respect to such policies.

(b) With respect to individual policies, not later than the earlier of the succeeding renewal date, if any, under such policies or one year, but in no event less than thirty days, from the date on which the association becomes obligated with respect to such policies.

(2) Make reasonable and diligent efforts to provide all known insureds or group policyholders with respect to group policies thirty days prior notice of the termination of the benefits provided.

(3) With respect to individual policies, make available to each known insured, or owner if other than the insured, and with respect to an individual formerly insured under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of R.S. 22:1395.7(D)(4), if the insureds had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy in force until a specified age or for a specified time, during which the insurer shall have no right to unilaterally alter any provision of the policy or undertake alterations only in premium by class.

(4)(a) In providing the substitute coverage required under R.S. 22:l395.7(D)(3), the association may offer either to reissue the terminated coverage or to issue an alternative policy.

(b) Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the former policy.

(c) The association may reinsure any alternative or reissued policy.

(5)(a) Alternative policies adopted by the association shall be subject to the prior approval of the commissioner. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency of an insurer.

(b) Alternative policies shall contain at least the minimum statutory provisions required in this state, and shall provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt in its plan of operation. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(c) Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

(6) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to the prior approval of the commissioner or by a court of competent jurisdiction.

(7) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date such coverage or policy is replaced by another similar policy by the policyholder, the insured, or the association.

E. When proceeding under R.S. 22:1395.7(B)(1) with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or credit of a rate of interest consistent herein.

F. Nonpayment of premiums within thirty-one days after the date required by the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the association's obligations under such policy or coverage under this Part with respect to such policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this Part.

G. Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association, and the association shall be liable for unearned premiums due to policy or contract owners arising after the entry of such order.

H. The protection provided by this Part shall not apply if any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

I. In carrying out its duties under R.S. 22:1395.7(B) and (C), the association may, subject to approval by the court:

(1) Impose permanent policy or contract liens in connection with any guarantee, assumption, or reinsurance agreement, if the association finds that the amounts which can be assessed under this Part are less than the amounts needed to assure full and prompt performance of this association's duties under this Part, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest.

(2) Impose temporary restraining orders or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value.

J. If the association fails to act within a reasonable period as provided in R.S. 22:1395.7(B) and (C), the commissioner shall have the powers and duties of the association under this Part with respect to impaired or insolvent insurers.

K. The association may render assistance and advice to the commissioner, upon his request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

L. The association shall have standing to appear before any court in this state with jurisdiction over an impaired or insolvent insurer concerning which the association shall become obligated under this Part. The standing shall extend to all matters germane to the powers and duties of the association, including but not limited to proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court in another state with jurisdiction over an impaired or insolvent insurer for which the association shall become obligated or with jurisdiction over a third party against whom the association may have rights through subrogation of the insurer's policyholders.

M.(1) Any person receiving benefits under this Part shall be deemed to have assigned the rights under, and any causes of action relating to, the covered policy or contract to the association to the extent of the benefits received because of this Part, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The association may require an assignment of such rights and cause of action by any payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this Part upon such person.

(2) The subrogation rights of the association under this Subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this Part.

(3) In addition to R.S. 22:1395.7(M)(1) and (2), the association shall have all rights of subrogation and any other equitable or legal remedy which would have been available to the impaired or insolvent insurer or holder of a policy or contract with respect to such policy or contracts.

N. The association may:

(1) Enter into such contracts as are necessary or proper to implement the provisions and purposes of this Part.

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments pursuant to R.S. 22:1395.8 and to settle claims or potential claims against it.

(3) Borrow money to effect the purposes of this Part. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets.

(4) Employ or retain such persons as are necessary to handle the financial and legal transactions of the association, and to perform such other functions as become necessary or proper under this Part.

(5) Take such legal action as may be necessary to avoid payment of improper claims.

(6) Exercise, for the purposes of this Part and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this Part.

O. The association may join an organization of one or more other state associations of similar purposes to further the purposes and administer the powers and duties of the association.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991.

§1395.8. Assessments

A. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary for the administration of the provisions of this Part. Assessments shall be due not less than thirty days after prior written notice to the member insurers and shall accrue interest at ten percent per annum on and after the due date.

B. There shall be two assessments, as follows:

(1) Class A assessments shall be made for the purpose of meeting administrative and legal costs and other expenses and examinations conducted under the authority of R.S. 22:1395.11. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer and their administration thereof.

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the association pursuant to R.S. 22:1395.7 with regard to an impaired or an insolvent insurer.

C.(1) The amount of any Class A assessment shall be determined by the board and shall not exceed one hundred fifty dollars per member insurer in any one calendar year. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances and established in the plan of operation.

(2) Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

(3) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be commenced by the board of directors until necessary to implement the purposes of this Part. Classification of assessments pursuant to Subsection B of this Section and computation of assessments pursuant to this Subsection shall be made with a reasonable degree of accuracy.

D. The association may abate or defer, in whole or in part, the assessment of an insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations. In the event an assessment against an insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other insurers in a manner consistent with the basis for assessments set forth in R.S. 22:1395.8.

E.(1) The total of all assessments upon an insurer for each account shall not in any one calendar year exceed two percent of such average premiums received of the insurers in this state on the policies and contracts covered by the account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in either account an amount sufficient to carry out the obligations of the association, the necessary additional funds shall be assessed as permitted by this Part.

(2) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

F. The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of that account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses.

G. It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of this Part, to consider the amount reasonably necessary to meet its assessment obligations under this Part.

H. The association shall issue to each insurer paying an assessment under this Part, other than Class A assessments, a certificate of contribution for Class B assessments, in a form prescribed by the commissioner for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991.

§1395.9. Plan of operation

A.(1) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective either upon the commissioner's written approval or thirty days after submission if he has not disapproved it.

(2) If the association fails to submit a suitable plan of operation within one hundred twenty days following September 30, 1991 or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Part. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall, in addition to requirements enumerated elsewhere in this Part:

(1) Establish procedures for handling the assets and liabilities of the association.

(2) Establish the amount and method of reimbursing members of the board of directors under R.S. 22:1395.6.

(3) Establish regular places and times for meetings, including telephone conference calls, of the board of directors.

(4) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors.

(5) Establish the procedures whereby selections for the board of directors shall be made and submitted to the commissioner.

(6) Establish any additional procedures for assessments pursuant to R.S. 22:1395.8.

(7) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

D. The plan of operation may provide that any or all powers and duties of the association, except those under R.S. 22:1395.7(M)(3) are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Any corporation, association, or organization which undertakes this function shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this Subsection shall take effect only with the prior approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this Part.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991.

§1395.10. Powers and duties of the commissioner

A. In addition to the duties and powers enumerated elsewhere in this Part, and in other provisions of law, the commissioner shall:

(1) Upon request of the board of directors, and notwithstanding any other law to the contrary, provide the association with a statement of the premiums, in this and any other appropriate states, for each member insurer.

(2) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. The notice to the impaired insurer shall constitute notice to its shareholders, if applicable. The failure of the insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under this Part.

(3) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

B. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer who fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may also levy a fine on any member insurer who fails to pay an assessment when due. The fine shall not exceed five percent of the unpaid assessment per month, but no fine shall be less than one hundred dollars per month.

C. Any action of the board of directors or the association may be appealed to the commissioner by any member insurer if such appeal is taken within sixty days of the final action being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the association and credited to meet association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount if paid in error or excess, shall be returned to the member company without interest. Any final action or order of the commissioner shall be subject to judicial review in a court of competent jurisdiction.

D. The rehabilitator, or conservator of any impaired insurer shall notify all interested persons of the effect of this Part.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991.

§1395.11. Prevention of insolvencies

A. To aid in the detection and prevention of insurer insolvencies or impairments, it shall be the duty of the commissioner:

(1)(a) To notify the commissioner of insurance, or other appropriate official, of all the other states, territories of the United States, and the District of Columbia when he takes any of the following actions against a member insurer:

(i) Revokes any license.

(ii) Suspends any license.

(iii) Makes any formal order that such company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders or creditors.

(b) Such notice shall be mailed to all such commissioners or other appropriate officials within thirty days following the action taken or the date on which such action occurs.

(2) To report to the board of directors when he has taken any of the actions set forth in R.S. 22:1395.11(A)(1) or has received a report from any other commissioner indicating that any such action has been taken in another state. Such report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner or other appropriate official.

(3) To report to the board of directors when he has reasonable cause to believe from any examination, whether completed or in process, of a member insurer that such member may be an impaired or insolvent insurer.

(4) To furnish to the board of directors of the National Association of Insurance Commissioners (NAIC), Insurance Regulatory Information System (IRIS), ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners. The board may then use the information contained therein in carrying out its duties and responsibilities. The report and the information contained therein shall be kept confidential by the board of directors.

B. The commissioner may seek the advice and recommendation of the board of directors concerning any matter affecting his duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

C. The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to transact insurance business in this state. Such reports and recommendations shall not be considered public documents.

D. It shall be the duty of the board of directors, upon majority vote, to notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

E.(1) The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within thirty days of the receipt of such a request, the commissioner shall begin such an examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the commissioner designates. The cost of such examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from complying with R.S. 22:1395.11(A).

(2) The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner but it shall not be open to public inspection prior to the release of the examination report to the public.

F. The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

G. The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report to the commissioner containing such information as it may have in its possession relative to the history and causes of the insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer and may adopt by reference any report prepared by such other association.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991.

§1395.12. Offsets for assessments paid

A. An insurer may offset against any premium or tax liability to the state an assessment not greater than twenty percent of the amount of such assessment for each of the five calendar years following the year in which such assessment was paid in full. In the event a member insurer should voluntarily cease doing business in this state, all uncredited assessments may be credited against any premium, franchise, or income tax due for the year it ceases doing business.

B. The amount of the assessment payable shall be reduced from the amount otherwise fixed in this Part if the insurer shall file a sworn statement with the annual report required by R.S. 22:291 through 295 as of December thirty-first for the reporting period that at least the following amounts of the total admitted assets of the insurer, less assets in an amount equal to the reserves on its policies issued in foreign countries in which it is authorized to do business and which countries require an investment therein as a condition of doing business, are invested and maintained in qualifying Louisiana investments as defined in R.S. 22:1068(C). If one-sixth of the total admitted assets of the insurer are in qualifying Louisiana investments, then the offset shall be sixty-six and two-thirds percent of the amount otherwise assessed. If at least one-fifth of the total admitted assets of the insurer are in qualifying Louisiana investments, then the offset shall be seventy-five percent of the amount otherwise assessed. If at least one-fourth of the total admitted assets of the insurer are in qualifying Louisiana investments, then the offset shall be eighty-five percent of the amount otherwise assessed. If at least one-third of the total admitted assets of the insurer are in qualifying Louisiana investments, then the offset shall be ninety-five percent of the amount otherwise assessed.

C. An insurer may transfer any offset as described in this Section with the prior approval of the commissioner to an affiliated insurer. For the purposes of this Section:

(1) "Affiliated insurer" means an insurance company licensed or holding a certificate of authority to do business in this state which controls, is controlled by, or is under common control with, another insurer.

(2) "Control" means holding, directly or indirectly, the ownership of, or power to vote, at least eighty percent of the voting stock of another member insurer.

D. Any sums which are acquired by refund, from the association by insurers, and which have theretofore been offset against premium, franchise and income taxes as provided in R.S. 22:1395.12(A), shall be paid by the insurers to this state in such manner as the tax authorities may require. The association shall notify the commissioner that such refunds have been made.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991.

§1395.13. Miscellaneous provisions

A. Nothing in this Part shall be construed to reduce or offset the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating a plan with assessment liability.

B. Records shall be maintained of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties. Records of such negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this Subsection shall limit the duty of the association to render a report of its activities pursuant to R.S. 22:1395.14.

C. For the purpose of carrying out its obligations under this Part, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to R.S. 22:1395.7(M). The assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this Part. The assets attributable to covered policies, are that proportion of the assets which the reserves that should have been established for the policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

D.(1) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, shareholders of the insolvent insurer, policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In such a determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties with respect to such insurer have been fully recovered by the association.

E.(1) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of R.S. 22:1395.13(E)(2) and (4).

(2) No such distribution shall be recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions received. Any person who was an affiliate that controlled, as defined in R.S. 22:1395.12(C)(2), the insurer at the time the distributions were declared, shall be liable up to the amount of distributions he would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this Subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(5) If any person liable under Paragraph (3) of this Subsection is insolvent, all its affiliates that controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991.

§1395.14. Examination of the association; annual report

The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner each year, not later than one hundred twenty days after the end of the fiscal year of the association, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991.

§1395.15. Tax exemption

The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions except taxes levied on immovable property.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991.

§1395.16. Immunity

There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer or its agents or employees, the association or its agents or emp loyees, members of the board of directors, or the commissioner or his representatives, for any action or omission by them in the performance of their powers and duties under this Part. Such immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991.

§1395.17. Stay of proceeding; reopening of default judgments

All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed sixty days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default, the association may apply to have such judgment set aside by the same court that entered such judgment and shall be permitted to defend against such suit on the merits.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991.

§1395.18. Prohibited advertisement of Insurance Guaranty Association Act in insurance sales; notice to policyholders

A. No person, including an insurer, agent, or affiliate of an insurer shall make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement, written or oral, which uses the existence of the Life and Health Insurance Guaranty Association of this state for the purpose of sales solicitation, or inducement to purchase any form of insurance covered by the Louisiana Life and Health Insurance Guaranty Association Act. This Section shall not apply to the Louisiana Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance.

B. Within one hundred eighty days of September 30, 1991, the association shall prepare a summary document describing the general purposes and current limitations of the Part and complying with R.S. 22:1395.12(C). This document shall be submitted to the commissioner for approval. Sixty days after receiving such approval, no insurer may deliver a policy or contract described in R.S. 22:1395.3(B)(1) to a policy or contract holder unless the document is delivered to the policy or contract holder prior to or at the time of delivery of the policy or contract except if R.S. 22:1395.18(D) applies. The document shall also be available upon request by a policyholder. The distribution, delivery, or contents or interpretation of this document shall not mean that either the policy or the contract or the holder thereof would be covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as amendments to this Part may require. Failure to receive this document shall not give the policyholder, contract holder, certificate holder, or insured any greater rights than those stated in this Part.

C. The document prepared pursuant to R.S. 22:1395.18(B) shall contain a clear and conspicuous disclaimer on its face. The commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall:

(1) State the name and address of the association and the insurance department.

(2) Prominently warn the policy or contract holder that the association may not cover the policy or, if coverage is available, it will be subject to substantial limitation, exclusions, and conditioned on continued residence in the state.

(3) State that the insurer and its agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance.

(4) Emphasize that the policy or contract holder should not rely on coverage under the association when selecting an insurer.

(5) Provide other information as directed by the commissioner.

D. No insurer or agent may deliver a policy or contract described in R.S. 22:1395.3(B)(1) and excluded by R.S. 22:1395.3(B)(2)(a) from coverage under this Part unless the insurer or agent, prior to or at the time of delivery gives the policy or contract holder a separate written notice which clearly and conspicuously discloses that the policy or contract is not covered by the association. The commissioner shall by rule specify the form and content of the notice.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Acts 1994, 3rd Ex. Sess., No. 92, §1.

§1395.19. Prospective application

This Part shall not apply to any insurer or its subsidiaries, insurance holding company system or related, either directly or indirectly, agents, affiliates, or other entities which are insolvent or impaired or unable to fulfill its contractual obligations before September 30, 1991.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991.

PART XXX. LOUISIANA INSURANCE RATING COMMISSION AND RATE REGULATION

SUBPART A. RATE MAKING PROCEDURES AND ORGANIZATIONS

§1401. Louisiana Insurance Rating Commission; creation, membership, selection, compensation, powers, duties, and functions; budgetary control; use of funds

A. The Louisiana Insurance Rating Commission is hereby created. The commission shall be composed of seven members, six of whom shall be appointed by the governor and the seventh member shall be the commissioner of insurance. Each appointment by the governor shall be submitted to the Senate for confirmation. Each appointed member shall serve a term concurrent with that of the governor making the appointment. The members appointed by the governor shall be resident citizens and qualified voters of this state. The commissioner of insurance shall serve as ex officio chairman of the commission.

B. The members of the commission shall be paid fifty dollars for each day of actual attendance at meetings of the commission or spent on business of the commission not to exceed twenty days in any month, payable on their own warrant, and in addition shall be paid for necessary expenses incurred in connection with actual attendance at meetings of the commission or while on business of the commission assigned by the commission, but only when properly vouchered.

C. Four members of the commission shall constitute a quorum for the transaction of business of the commission.

D. The domicile of the commission shall be in the city of Baton Rouge, where it shall maintain its principal office.

E. The office of property and casualty of the Department of Insurance shall facilitate the functions and activities of the Louisiana Insurance Rating Commission. As used in this Part, the term "office of property and casualty" shall mean the office of property and casualty of the Department of Insurance, and the term "commission" shall mean the Louisiana Insurance Rating Commission.

F. The legislature hereby specifically states that the provisions of this Section are in no way and to no extent intended to nor shall they be construed in any manner which will impair any contractual obligations as they existed prior to September 1, 1972.

G. - H. REPEALED BY ACTS 2003, No. 456, §2.

I. Except as provided in R.S. 22:1401.1, the Louisiana Insurance Rating Commission may approve in whole or in part any application for rate change brought by an insurer before the commission, such approval or partial approval to be made pursuant to the commission's analysis of the data presented and any other factors relevant to the application. However, if an application for a rate change brought by an insurer is approved in part by the commission, the insurer shall be given the option to withdraw such application but must exercise such option within fourteen days after the commission's action.

J.(1) The commission shall not approve a rate increase for any insurer more than once per rate classification in any twelve-month period. An application for a rate change which reduces insurance rates for a risk classification may be approved at any time.

(2) Except as provided herein, overall average rate level increases or decreases in any twelve-month period, for all coverages combined for both personal and commercial lines, of ten percent above or below the insurer's rates in effect, may take effect without prior approval as provided in Paragraph (3) of this Subsection. The ten percent limitation does not apply on an individual insured basis. Notwithstanding any other provisions of this Part, for any policies governed by this Section, filings that produce rate level changes within the limitation specified herein, become effective without prior approval, provided that notice is given to the policyholders in accordance with Paragraph (4) of this Subsection.

(3)(a) A rate increase or decrease falling within the said limitation may become effective not less than thirty days after the date of the filing with the commission. Any such filing is deemed to meet the requirements of this Part. The actuarial staff of the commission and the office of property and casualty may find that such filing is not in compliance with this Part; however, the actuarial staff shall issue a written order specifying in detail the provisions with which the insurer has not complied and state a reasonable period in which the filing shall be deemed no longer effective. Any such order that is issued more than thirty days from the date on which the commission received the rate filing, shall be on a prospective basis only and shall not affect any contract issued or made prior to the effective date of the order. Any such order may be appealed by the filing insurer to the commission. Rate filings falling outside of the said limitation shall be subject to the prior approval by the commission as otherwise provided by law.

(b) Individual insurance companies and member companies of an affiliated group of insurers may utilize different filed rates for insurance coverage in accordance with rating plans filed with the commission. These rating plans may provide for different rates, rating tiers, and rating plans among affiliated companies. For the purposes of this Paragraph, an affiliated group of insurers includes a group of insurers under common ownership, management, or control.

(4) Prior to the implementation of a rate change approved by the commission, or deemed approved pursuant to this Subsection, which increases a rate for a policyholder, the insurer shall notify the policyholder at least thirty days prior to the date of renewal of the policy. No rate increase approved by the commission, or deemed approved pursuant to this Subsection, shall be implemented by the insurer during the term contracted between the policyholder and the insurer. The overall statewide rate change implemented under this Subsection must be stated in the notice to the policyholder.

(5) For the purposes of this Subsection:

(a) The effective date of a rate change shall be the effective date provided for in the rate filing.

(b) The date used to determine the beginning of a twelve-month period shall be the effective date for the last approved rate change.

(c) The first application for a rate change after an initial rating plan is approved by the commission is not subject to the twelve-month period.

(6) On or before February 1, 2008, the Louisiana Insurance Rating Commission shall deliver to the legislature a report on flexible rating for property and casualty insurance. The report may not include data regarding a specific insurer or insurer group, unless that data is public record. The report shall analyze the impact of the flexible rating on:

(a) The extent and nature of competition.

(b) The size and significance of coverage.

(c) The level and range of rates and rate changes among insurers.

(d) The extent of consumer complaints to the Department of Insurance.

(e) The volume of cancellations and nonrenewals.

(f) The changes in the number of policies by territory and by class, including age and sex in each territory.

(g) The number of new insured and nonrenewed insured.

(h) The business written by each insurer.

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1; Acts 1960, No. 571, §1; Acts 1962, No. 82, §1; Acts 1967, No. 22, §1; Acts 1970, No. 300, §1; Acts 1970, No. 307, §1; Acts 1972, No. 591, §1, eff. Sept. 1, 1972; Acts 1977, No. 269, §1, eff. July 7, 1977; Acts 1980, No. 775, §1, eff. July 31, 1980; Acts 1983, No. 310, §1; Acts 1985, No. 520, §2; Acts 1988, No. 358, §1, eff. Sept. 1, 1988; Acts 1993, No. 1022, §1; Acts 1999, No. 66, §1; Acts 2002, 1st Ex. Sess., No. 160, §1, eff. June 16, 2002; Acts 2003, No. 351, §1, eff. January 1, 2004; Acts 2003, No. 456, §§1 & 2; Acts 2003, No. 774, §5; Acts 2004, No. 878, §1, eff. January 1, 2005.

§1401.1. Rates for commercial lines of property and casualty insurance

A. The office of property and casualty shall have the exclusive authority to accept, review, and approve any application for insurance rates or rate changes for all lines of commercial property and casualty insurance. The office of property and casualty shall exercise its authority in accordance with the provisions of this Section.

B. Subject to the exception specified in Subsection C of this Section, each filing submitted to the office of property and casualty shall be on file for a waiting period of forty-five days before it becomes effective. Upon written application by such insurer or rating organization, the office of property and casualty may authorize a filing which it has reviewed to become effective before the expiration of the waiting period. A filing shall be deemed to meet the requirements of this Part unless disapproved in writing by the office of property and casualty within the forty-five-day waiting period. The office of property and casualty may by rule, regulation, or order reduce or eliminate the waiting period specified in this Section. For any filing that is disapproved, the insurer may appeal such disapproval to the Louisiana Insurance Rating Commission within fifteen days from the receipt of written notice of disapproval.

C. Insurers negotiating with and insuring commercial entities, except with regard to workers' compensation and medical malpractice insurance, with at least ten thousand dollars in annual insurance premiums shall be required to file insurance rates or rate changes for such entities with the office of property and casualty for informational purposes only. The office of property and casualty may by rule, regulation, or order reduce or eliminate the annual premium threshold for commercial entities that enables rate filings to be made under this Section.

D. All provisions of this Section shall be applicable when a competitive market in commercial lines insurance exists. The commissioner of insurance shall adopt rules and regulations to determine if there exists a competitive or noncompetitive market. At a minimum those rules shall require reasonable notice and a hearing prior to determining a market to be noncompetitive. If, after a hearing, the commissioner determines the market to be noncompetitive, all commercial rate filings shall follow the provisions of Subsection B of this Section without regard to the exception specified in Subsection C of this Section.

E. No provision of this Section shall prohibit the Department of Insurance from conducting market conduct exams to ensure the rates being charged by insurers are adequate, not excessive, or unfairly discriminatory.

Added by Acts 2004, No. 878, §1, eff. January 1, 2005.

§1402. Purpose of rate regulation

The purpose of this Part is to promote the public welfare by regulating insurance rates to the end that they shall not be excessive, inadequate, or unfairly discriminatory, and to authorize and regulate cooperative action among insurers in rate making and in other matters within the scope of this Part. Nothing in this Part is intended (1) to prohibit or discourage reasonable competition, or (2) to prohibit or encourage, except to the extent necessary to accomplish the aforementioned purpose, uniformity in insurance rates, rating systems, rating plans or practices. This Part shall be liberally interpreted to carry into effect the provisions of this Section.

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1.

§1403. Scope of rate regulation

A. This Part applies to fire, marine and transportation (inland marine), title insurance and casualty insurance risks or operations in this state.

B.(1) For the purpose of this Part, fire insurance includes insurance coverage as defined in R.S. 22:6(10), (11)(b), and (12), and such other coverages as are usually written by fire insurers other than motor vehicle insurance; marine and transportation (inland marine) insurance includes personal floater insurance and the kinds of insurance defined in R.S. 22:6(13) and such other inland marine coverages as may be so established by interpretation, by ruling of the commission, or by general customs of the business; title insurance includes the kind of insurance coverage as defined in R.S. 22:6(9), and casualty insurance includes the kinds of casualty insurance defined in R.S. 22:6(3), (4), (5), and (6), except personal property floater, R.S. 22:6(7), (8), and (11)(a), and such other coverages as are usually written by casualty insurers.

(2) Notwithstanding any other law to the contrary, any authorized insurer or approved unauthorized insurer providing liability coverage for public carrier vehicles, as defined by R.S. 45:200.2(2), shall be subject to the provisions of this Part.

C. This Part shall not apply:

1. To reinsurance, other than joint reinsurance to the extent stated in R.S. 22:1414.

2. To insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity; or other risks commonly insured under marine, as distinguished from inland marine, insurance policies.

3. To insurance against loss or damage to aircraft or against liability, other than worker's compensation and employers' liability arising out of the ownership, maintenance or use of aircraft, nor to insurance of hulls of aircraft, including their accessories and equipment.

4. To health and accident insurance.

D. If any kind of insurance, subdivision or combination thereof or type of coverage is subject to regulation under Sections of this Part, the provisions of which conflict, an insurer to which such conflicting provisions are otherwise applicable shall file with the commission a designation as to which of said sections shall be applicable to it with respect to such kind of insurance, subdivision or combination thereof or type of coverage.

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1; Acts 1983, 1st Ex. Sess., No. 1, §6; Acts 2002, 1st Ex. Sess., No. 160, §1.

§1404. Making of rates

All rates shall be made in accordance with the following provisions:

(1) Due consideration shall be given to past and prospective loss experience within and outside this state, to catastrophe hazards, if any, to a reasonable margin for underwriting profit and contingencies, to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, to past and prospective expenses both countrywide and those specially applicable to this state, and to all other relevant factors within and outside this state.

(2) Rates shall not be excessive, inadequate or unfairly discriminatory.

(3) Rates for casualty insurance to which this Part applies shall also be subject to the following provisions:

(a) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.

(b) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Rates may be established on the basis of any classifications submitted by any insurer or group of insurers, provided such classifications are found to be reasonable. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses.

(c)(i) A rate reduction of up to ten percent shall be authorized by the Louisiana Insurance Rating Commission, if actuarially justified, upon application of a rate filing by the carrier on motor vehicle liability and physical damage insurance where the insured and principal operator, regardless of age, produces certification from the National Safety Council or its registered cooperating agencies, evidencing successful completion of the National Safety Council Defensive Driving Course or certification of successful completion of a defensive driving course approved and certified by the Department of Public Safety and Corrections. Should an automobile be used by multiple drivers, the rate reduction shall not be authorized on that automobile unless all those who drive the automobile complete such a course successfully. The reduction provided for in this Section shall also be authorized for one or more motor vehicles owned and operated by parishes, municipalities, or other political subdivisions when the governing authority produces certification evidencing successful completion of such a course by all persons who drive said vehicles. The Department of Public Safety and Corrections, Public Safety Services, office of state police may promulgate rules and regulations to establish criteria and standards for the approval and certification of defensive driving courses. The expenses of the approval and certification process by the Department of Public Safety and Corrections shall be funded through an interagency agreement with the Department of Insurance, contingent upon the appropriation of funds by the legislature.

(ii)The form of certification shall be as determined by the Louisiana Insurance Rating Commission. The credit shall not apply to experience rated or assigned risk policies, or to policies subject to a discount for an approved driver education course sanctioned by the Department of Education, or required to pay a substandard risk surcharge for such insurance, or to any person whose enrollment in a defensive driving course resulted from a court order or sentence directing such enrollment.

(iii) Such credit shall apply to new and renewal policies effective within a period of thirty-six months subsequent to the date of completion of the course. Following such thirty-six month period, in order to again qualify for such credit, the course must be successfully repeated and evidence again presented. A fee of one dollar or such other sum approved by the Louisiana Insurance Rating Commission may be charged by the National Safety Council, its registered cooperating agencies, or operators of any approved and certified defensive driving course for certifying course completion. If the policy insures two or more automobiles the credit shall apply only to that automobile principally operated by a person who has satisfactorily completed such a course.

(d)(i) The provisions of Subparagraph (c) notwithstanding, the Louisiana Insurance Rating Commission shall authorize an actuarially justified rate reduction, as determined by the carrier, upon application of rate filing by the carrier on bodily injury liability, property damage liability, and collision insurance where the named insured and principal operator is fifty-five years of age or older and produces certification from the National Safety Council or its registered cooperating agencies evidencing successful completion of the National Safety Council Defensive Driving Course or certification of successful completion of a defensive driving course approved and certified by the Department of Public Safety and Corrections. Should a vehicle be used by multiple drivers, the rate reduction shall not be authorized on that motor vehicle unless all those who drive the vehicle are fifty-five years of age or older and have completed such a course. The Department of Public Safety and Corrections, Public Safety Services, office of state police may promulgate rules and regulations to establish criteria and standards for the approval and certification of defensive driving courses. The expenses of the approval and certification process by the Department of Public Safety and Corrections shall be funded through an interagency agreement with the Department of Insurance, contingent upon the appropriation of funds by the legislature.

(ii) The reduction shall not apply to experience-rated or assigned risk policies or to any person eligible for a preferred rating plan or required to pay a substandard risk surcharge for such insurance or to any person whose enrollment in a defensive driving course resulted from a court order or sentence directing his enrollment.

(iii) Such a reduction shall apply to new and renewal policies effective within a period of thirty-six months subsequent to the date of completion of a course. Following the thirty-six-month period, the course shall be successfully repeated and evidence again presented in order to again qualify for such credit. A fee of one dollar or such other sum approved by the Louisiana Insurance Rating Commission may be charged by the National Safety Council, its registered cooperating agencies, or the operators of any approved and certified defensive driving course for certifying course completion. If the policy insures two or more vehicles, the reduction shall apply only to that vehicle principally operated by the eligible person.

(e) An insurer who delivers or issues for delivery in this state comprehensive insurance coverage on a motor vehicle shall grant an actuarially justified discount in the amount approved by the Louisiana Insurance Rating Commission in the premiums charged for the comprehensive insurance for any motor vehicle when the vehicle identification number of the vehicle is etched into all of the windows of such motor vehicle. The letters and numbers of the vehicle identification number shall be no smaller than one-eighth of an inch and shall be nonremovable and permanent.

(f) A rate reduction shall be authorized by the Louisiana Insurance Rating Commission, if actuarially justified, upon application of a rate filing by the carrier on motor vehicle liability and physical damage insurance for coverage of any motor vehicle when the insured vehicle is equipped with daytime running headlights or headlights equipped to activate in inclement weather.

(4) Rates for fire, marine, and inland marine insurance to which this Part applies shall also be subject to the following provisions:

(a) Manual, minimum class rates, rating schedules or rating plans, shall be made and adopted, except in the case of specific inland marine rates on risks specially rated.

(b) Due consideration shall be given to the conflagration and other catastrophe hazards, and in the case of fire insurance rates consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent five-year period for which such experience is available.

(c) For fire insurance rates, all insurers shall assign the fire protection grade of the fire servicing area where the property of the insured is located, provided that the property is located within seven road miles of the nearest responding fire department.

(5) Except to the extent necessary to meet the provisions of Paragraph (2) of this Section, uniformity among insurers in any matters within the scope of this Section is not required nor prohibited. Nothing in this Code shall be construed to prohibit any insurer from deviating upon proper approval under this Part from any loss cost established by a rating organization or the commission, provided the rate used is adequate; to prevent any insurer upon proper approval under this Part from issuing policies for periods of time and at rates approved by the commission; or from charging in addition to the premium a separate initial membership, policy, inspection fee, interim title insurance binder fee, or other similar charge.

(6) The term "rate" as used in this Part shall include, as the context may require, either the premium to be paid by or charged to the insured for insurance, including fees and charges referred to in paragraph (5) of this Section, or the elements and factors forming the basis for the determination of the premium, including fees and charges referred to in paragraph (5) of this Section.

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1; Acts 1975, No. 175, §1. Acts 1983, No. 518, §1; Acts 1984, No. 816, §1; Acts 1984, No. 872, §1; Acts 1992, No. 654, §1; Acts 1995, No. 223, §1; Acts 1997, No. 724, §1; Acts 2001, No. 169, §1; Acts 2003, No. 456, §1; Acts 2003, No. 1093, §1; Acts 2004, No. 239, §1.

§1404.1. Disclosure of financial condition for determination of rate increase

The Department of Insurance or its successor may require any insurer to furnish to it any financial information which it may request concerning the financial condition of the insurer. The Insurance Rating Commission may inspect records of an insurer or a rating organization at the home office or any branch office of such an insurer or rating organization.

Added by Acts 1978, No. 595, §1; Acts 1997, No. 649, §1.

§1404.2. Examinations and investigations; subpoena; discovery

While conducting any examination or investigation, under R.S. 22:1404.1 or otherwise as may be provided by provisions of this Part, the commission by majority vote may instruct the commissioner of insurance to obtain testimony or records or other materials for the use of the commission under the powers he possesses in R.S. 22:1309 and R.S. 22:1310. The provisions of R.S. 22:1315 shall apply to any testimony, record, or other material obtained under the provisions of this Section.

Acts 1986, No. 843, §1.

§1404.3. Premium on criminal bail bond

The premium rate set for commercial surety underwriters writing criminal bail bonds in the various courts throughout the state of Louisiana shall not be subject to the Louisiana Insurance Rating Commission's rates, but shall be set and adjusted by the legislature. The rate for all commercial surety underwriters writing criminal bail bonds in the state of Louisiana shall be twelve percent of the face amount of the bond, or sixty dollars, whichever is greater. Any additional fee authorized by R.S. 13:718(I)(2) shall not be included in this premium rate and shall be exclusive of the limit set by this Section. All other provisions of the code relating to enforcement of the rate shall be effective and enforced in accordance with all parts of this Section.

Acts 1993, No. 834, §5, eff. June 22, 1993; Acts 1999, No. 135, §1; Acts 1999, No. 717, §1.

§1405. Fire insurance rates; the Property Insurance Association of Louisiana

A. Every insurance company authorized to write fire insurance in this state shall adhere to the rates promulgated by The Property Insurance Association of Louisiana as provided in this Section, and approved by the Louisiana Insurance Rating Commission, except that any such insurer may deviate from such rates in accordance with R.S. 22:1410. Nothing in this Section shall be construed to require adherence to association rates by companies insuring special or particular kinds or classes of risks in connection with which an inspection or engineering service is maintained, provided rates for such risks are filed with the Louisiana Insurance Rating Commission through a duly licensed company or through a rating organization licensed under R.S. 22:1409.

B.(1) The Property Insurance Association of Louisiana shall be continued and every insurance company, now or hereafter licensed and authorized to write fire insurance in this state, shall belong to such association.

(2) The board of directors of the association shall be residents of this state and consist of seventeen members, as follows:

(a) One member shall be the commissioner of insurance or his designee.

(b) Two members shall be appointed by the commissioner of insurance, and each appointment shall be subject to confirmation by the Senate.

(c) One member shall be a representative designated by the Louisiana Insurance Rating Commission.

(d) One member shall be a representative designated by the Professional Insurance Agents of Louisiana.

(e) One member shall be a representative designated by the Independent Insurance Agents of Louisiana.

(f) One ex officio member who shall be the chairman of the House Committee on Insurance or a member of that committee designated by him.

(g) One ex officio member who shall be the chairman of the Senate Committee on Insurance or a member of that committee designated by him.

(h) Nine members who shall be elected from and by the membership of the association. These nine members shall be properly apportioned as between stock and nonstock members predicated on the ratio of their net fire insurance premiums for the calendar year immediately preceding said election. Said net fire insurance premiums shall be furnished the association by the commissioner of insurance.

(3) Each board member shall be entitled to one vote, except that the legislative members serving pursuant to Subparagraphs (f) and (g) of Paragraph (2) of this Subsection shall be nonvoting members who shall also not be counted for the purposes of a quorum. The officers shall consist of a president, vice president, and secretary-treasurer. The bylaws may provide for such other officers and employees as may be deemed necessary or advisable. The main office of the association shall be in the city of New Orleans, and branch offices may be established throughout this state.

C. The Louisiana Insurance Rating Commission shall review the rates promulgated by the association or other rating organization to determine whether they meet the requirements of this Part. Such review shall be made in the same manner and subject to the same procedure as is provided in R.S. 22:1407.

D. The powers and duties of the association shall be:

(1) To inspect or cause to be inspected every risk specifically rated by schedule for property damage insurance and to make a written survey of such risk, which shall be filed as a permanent record in the main office of the association. Present inspections and surveys may be used in lieu of new inspections and surveys. Such survey or schedule shall give in detail the defects either of construction or of occupancy, or both, existing in the risk which affect the property damage rate. The rate at which the risk must be written by the members of the association shall be stated in the survey together with the relative measure which each defect bears to the fire hazard as a whole and to the basic cost of the same and the consequent proportionate value of each improvement suggested to minimize the chances of fire so that each assured may be informed as to the manner in which his rate was determined and the measures which should be taken to effect a reduction in the rate and the sum of each reduction. The records of the association shall be exempt from the application of R.S. 44:1 et seq., except that a copy of such survey shall be furnished, upon request, to the owner of every risk, or to any member company or resident agent, provided said company has a policy in effect on the risk, without expense to said owner.

(2) To make rates on fire and extended coverage insurance as defined in Paragraphs (10) and (11b) of R.S. 22:6 and on such other coverages as are usually written by fire insurers on property other than motor vehicle insurance located in this state, in accordance with the provisions of this part. Provided, however, that by and with the approval of the commission, other rating organizations created for the purpose of making and promulgating rates for special or particular kinds or classes of business written by fire insurance companies may be licensed under the terms or conditions of this part.

(3) To audit, on special call by the association, policies written by member companies in compliance with filings as approved or made in accordance with the provisions of this Part.

(4) To survey municipal areas for publication of public fire protection grading.

(5) To file fire insurance rating schedules with the Louisiana Insurance Rating Commission.

(6) To review building plans and specifications and fire suppression system plans and specifications when submitted to it for review, and to offer nonbinding recommendations for upgrading the fire insurance rating.

(7) To review fire suppression system plans, when submitted to it, and to offer nonbinding recommendations to upgrade fire protection gradings of municipal areas.

(8) To promulgate average rates.

(9) To design and file policy forms with the department.

(10) To perform such functions, to engage in such activities, to employ personnel, consultants, and counsel, and to acquire equipment and facilities adequate to exercise the powers and duties authorized by law in order to encourage and promote programs, legislation, and regulations calculated to produce and maintain a healthy and competitive property insurance market in Louisiana for the benefit of the insuring public.

E.(1) Expenses of the association shall be paid by its members and subscribers through assessments levied upon them by the association equitably in proportion to services rendered by the association to the individual member which, insofar as possible, shall be in proportion to the direct premiums, less returned premiums, received in this state by each insurer in the year before the preceding year, provided that any insurer member which has not operated in this state for the two full years next preceding the assessment shall be required to pay a proportionate payment based upon that part of the penultimate year it was operating in this state. Members who deviate from association rates shall be assessed on an amount of premium that would have been received had the association rates been charged. Any member-insurer may appeal to the commissioner of insurance to review and modify its assessment to assure that the assessment complies with the provisions of this Section. Credit in assessment shall not be taken for dividends paid to policyholders. The association shall have the right to charge subscribers for services rendered, and to charge members and subscribers reasonable entrance and annual membership and subscription fees.

(2) Upon the failure of any member or subscriber of the association to pay its lawful proportion of said expenses and the fees due by it, within thirty days after the same is due and payable, the association shall refuse to furnish its services to said delinquent and shall report such delinquency to the commissioner of insurance, who for such delinquency shall suspend or revoke the license of the delinquent member insurer.

F. The association shall be subject to all the provisions of this Part, except R.S. 22:1406, governing and regulating other rating organizations hereunder.

G. Debit fire insurance policies are defined as policies issued by companies which write fire insurance through debit agents operating on the debit agency system and which meet the other requirements of this section. The method of premium payment for debit fire insurance in the State of Louisiana shall be only on a monthly or more frequent basis from the date this act becomes effective. No debit insurance policy shall be issued for an annual or less frequent premium.

Rates for debit fire insurance and allied lines shall be filed directly with the Louisiana Insurance Rating Commission and shall be approved and supervised as to both initial filings and requested changes only by the said Louisiana Insurance Rating Commission. In all other respects, the commissioner of insurance shall have sole supervision and regulation of the operation of debit fire insurance and allied lines in the State of Louisiana, such insurers being specifically exempt from the assessments levied by the association.

H. There shall be no liability on the part of and no cause of action of any nature shall arise against the Property Insurance Association of Louisiana or any of its officers, directors, or employees, or against any of its members for any inspections, audits or other statutory duties performed hereunder or any statements made in good faith by them in any reports or communications concerning risks submitted to the association, or at any administrative hearing conducted in connection therewith under the provisions of this Part.

I.(1)(a) Every insurance company authorized to write fire insurance in this state shall adhere to the rates promulgated by the Property Insurance Association of Louisiana and approved by the Louisiana Insurance Rating Commission in accordance with Subsection A of this Section; however, whenever a public protection classification is changed to reflect improved fire protection in an area or for a governmental entity, the insurer shall reduce its premium for that policy and when the insurance protection class improves from a class two to a class one, the percentage amount of such premium reduction shall be uniform for all policies in the area whether the property is classified as commercial or residential. This reduction shall be granted prior to the next policy renewal or within sixty days from the effective date of the change in the public protection classification, whichever occurs first.

(b) Whenever a public protection classification is changed to reflect a detrimental change in fire protection in an area or for a governmental entity, an insurer may adjust its premium for that policy and the percentage amount of such adjustment shall be uniform for all policies in the area whether the property is classified as commercial or residential.

(2) The commission shall assess a penalty fine against any insurer which does not reduce its premium within the time periods specified in Paragraph (1) of this Subsection. The penalty shall be in an amount assessed by the commission but it shall be not less than one thousand dollars and not more than five thousand dollars per violation.

(3) All records of the Property Insurance Association of Louisiana that were used to determine the classification of a public fire protection area shall be open to inspection during normal business hours and upon reasonable notice given by the fire chiefs and the principal elected officials or their designees within the fire protection area. "Principal elected officials" means the mayors of towns, cities, and municipalities and the presidents of police juries.

Acts 1958, No. 125. Amended by Acts 1958, No. 128, §§1-4; Acts 1960, No. 296, §1; Acts 1962, No. 53, §1; Acts 1966, No. 136, §1; Acts 1974, No. 429, §1; Acts 1975, No. 311, §1; Acts 1979, No. 155, §1; Acts 1979, No. 646, §1; Acts 1987, No. 931, §1; Acts 1990, No. 252, §1; Acts 1995, No. 158, §1; Acts 1995, No. 326, §1; Acts 1999, No. 837, §1; Acts 1999, No. 1023, §1; Acts 2003, No. 456, §1; Acts 2003, No. 628, §1.

§1406. Specific duties of the Louisiana Insurance Rating Commission

A. Every insurance company, reciprocal or exchange, authorized to write casualty insurance, including vehicle insurance, within the scope of this Part shall adhere to rates as approved by the commission. Rates filed in accordance with the provisions of R.S. 22:1407(F) shall be subject to review as provided in R.S. 22:1408(C), and any insurer may apply for a deviation in accordance with R.S. 22:1410.

B. The commission, after review, shall approve territorial definitions and classification plans for all casualty insurance coverages, as incorporated in rate and rule filings submitted by insurers, and such territories and classification plans shall be adhered to as approved, provided that nothing in this Subsection shall be construed as requiring uniformity in insurance rates.

C. REPEALED BY ACTS 2003, No. 456, §2.

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1; Acts 1962, No. 187, §1; Acts 1964, No. 118, §1; Acts 1964, No. 138, §1; Acts 1966, No. 136, §1; Acts 1970, No. 345, §1; Acts 1972, No. 137, §1, eff. Jan. 1, 1973; Acts 1972, No. 550, §1; Acts 1974, No. 154, §1; Acts 1975, No. 494, §1; Acts 1975, No. 656, §1; Acts 1976, No. 674, §1, eff. Aug. 5, 1976; Acts 1977, No. 438, §1; Acts 1977, No. 623, §1; Acts 1978, No. 543, §2; Acts 1980, No. 510, §3; Acts 1980, No. 621, §3; Acts 1986, No. 544, §1; Acts 1987, No. 436, §1; Acts 1987, No. 439, §1; Acts 1987, No. 444, §1; Acts 1988, No. 203, §1; Acts 1988, No. 233, §1, eff. July 6, 1988; Acts 1989, No. 438, §1; Acts 1990, No. 301, §1; Acts 1990, No. 634, §1; Acts 1990, No. 677, §1; Acts 1991, No. 626, §1; Acts 1991, No. 806, §1; Acts 1992, No. 335, §1; Acts 1992, No. 583, §1; Acts 1992, No. 980, §1; Acts 1993, No. 142, §1; Acts 1993, No. 834, §6, eff. June 22, 1993; Acts 1997, No. 951, §1; Acts 1997, No. 1476, §3, eff. Sept. 6, 1998; Acts 1999, No. 732, §1; Acts 2003, No. 456, §§1, 2, and 3.

NOTE: See Acts 1997, No. 1476, §5(D)(2). The rate reduction day was the date on which the judgment in the lawsuit became final, May 8, 1998. Sections 2 through 4 became effective 120 days thereafter, Sept. 6, 1998.

§1406.1. REPEALED BY ACTS 2003, No. 1133, §2.
§1406.2. REPEALED BY ACTS 2003, No. 1133, §2.
§1406.3. REPEALED BY ACTS 2003, No. 1133, §2.
§1406.4. REPEALED BY ACTS 2003, No. 1133, §2.
§1406.5. REPEALED BY ACTS 2003, No. 1133, §2.
§1406.6. REPEALED BY ACTS 2003, No. 1133, §2.
§1406.7. REPEALED BY ACTS 2003, No. 1133, §2.
§1406.8. REPEALED BY ACTS 2003, No. 1133, §2.
§1406.9. REPEALED BY ACTS 2003, No. 1133, §2.
§1406.10. REPEALED BY ACTS 2003, No. 1133, §2.
§1406.11. REPEALED BY ACTS 2003, No. 1133, §2.
§1406.12. REPEALED BY ACTS 2003, No. 1133, §2.
§1406.13. REPEALED BY ACTS 2003, No. 1133, §2.
§1406.14. REPEALED BY ACTS 1992, NO. 424, §2.
§1407. Rate filing

A.(1) Every insurer whose rates are subject to regulation under the provisions of this Part shall file with the office of property and casualty, except as to excess insurance coverage, and inland marine risks which by general custom of the business are not written according to manual rates or rating plans, every manual, minimum, class rate, rating schedule or rating plan and every other rating rule, and every modification of any of the foregoing which it proposes to use. Every such filing shall state the proposed effective date thereof and shall indicate the character and extent of the coverage contemplated. Specific inland marine rates on risks specifically rated, made by a rating organization, shall be filed with the office of property and casualty.

(2) When a filing made pursuant to this Subsection is not accompanied by the information upon which the insurer or rating organization supports such filing, and the office of property and casualty does not have sufficient information to determine whether such filing meets the requirements of this Part, it shall require such insurer or rating organization to furnish the information upon which it supports such filing, and in such event the waiting period shall commence as of the date such information is furnished. The information furnished in support of a filing may include:

(a) The experience or judgment of the insurer or rating organization making the filing,
(b) Its interpretation of any statistical data it relies upon,
(c) The experience of other insurers or rating organizations, or
(d) Any other relevant facts.
(e) A filing and all information pertaining thereto shall be open to public inspection when filed.

(3) The Louisiana Insurance Rating Commission is authorized to verify statistical data included in any filing made pursuant to this Section either by requiring substantiating written documentation or by inspecting records of insurers or rating organizations at home or branch offices of such organizations.

B. Each insurer shall satisfy its obligation to make such filings by filing its rate requests individually with the Louisiana Insurance Rating Commission. A specific rate for an insurer may only be filed by that insurer, except as designated or authorized by the Louisiana Insurance Rating Commission because of lack of credibility of data in the statistical base. Informational filings may be made by a licensed rating organization, but such informational filings shall not include specific rates, except as provided in R.S. 22:1409(G). An insurer may become a member of, or a subscriber to, a licensed rating organization which makes informational filings; provided that, except with respect to mandatory membership in the Property Insurance Association of Louisiana as provided in R.S. 22:1405, nothing contained in this Part shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization.

C. The commission shall review filings as soon as reasonably possible after they have been made with it in order to determine whether they meet the requirements of this Part, and no such filings shall become effective except as provided in this Part.

D. Subject to the exceptions specified in Subsections E and F of this Section, each filing shall be on file for a waiting period of forty-five days before it becomes effective. Upon written application by such insurer or rating organization, the commission may authorize a filing which it has reviewed to become effective before the expiration of the waiting period. A filing shall be deemed to meet the requirements of this Part unless disapproved by the commission within the waiting period in accordance with R.S. 22:1408.

E. Specific inland marine rates on risks specially rated by a rating organization shall become effective when filed and shall be deemed to meet the requirements of this Part until such time as the commission reviews the filing and so long thereafter as the filing remains in effect.

F. When a filing of adjustments of rates for existing classifications of risks (1) does not involve a change in the relationship between such rates and the expense portion thereof, and (2) does not involve a change in rate relativities among such classifications on any basis other than loss experience, such filing shall become effective upon the date or dates specified in the filing and shall be deemed to meet the requirements of this Part: provided that this Subsection shall not apply to public property rates as provided for under R.S. 22:1421, nor to surety or worker's compensation insurance.

G. Under such rules and regulations as the commission shall adopt, the commission may, by written order, suspend or modify the requirements of filing as to any kind of insurance, subdivision, or combination thereof, or as to classes of risks, the rates for which cannot practicably be filed before they are used. Such order, rules, and regulations shall be made known to insurers and to rating organizations affected thereby. The commission may make such examination as it may deem advisable to ascertain whether any rates affected by such order meet the requirement of filing as to any kind of insurance, subdivision, or combination thereof, or as to classes of risks, the rates for which cannot practicably be filed before they are used. Such orders, rules, and regulations shall be made known to insurers and rating organizations affected thereby. The commission may make such examination as it may deem advisable to ascertain whether any rates affected by such order meet the standards set forth in R.S. 22:1404(2).

H. Upon the written application of the insured, stating his reasons therefor, filed with and approved by the commission, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

I. Any rate being legally utilized by an insurer on September 1, 1988 shall remain in full force and effect until changed by the insurer through a rate filing approved by the Louisiana Insurance Rating Commission.

J. REPEALED BY ACTS 2003, No. 456, §2.

K. Any insurance company licensed to issue workers' compensation insurance policies in the state of Louisiana, whose rates are subject to the provisions of this Part, may file rates on an actuarially justified class code basis with the Louisiana Insurance Rating Commission and use the rates ninety days after the filing. Insurance companies licensed to issue workers' compensation policies shall not file and use any rates in excess of an average of twenty percent annually of its workers' compensation insurance rates in the state without prior approval of the Insurance Rating Commission.

L. REPEALED BY ACTS 2003, No. 456, §2.

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1; Acts 1964, No. 362, §1; Acts 1966, No. 136, §1; Acts 1978, No. 523, §1; Acts 1978, No. 525, §1; Acts 1983, 1st Ex. Sess., No. 1, §6; Acts 1988, No. 357, §1, eff. Sept. 1, 1988; Acts 1991, No. 814, §2; Acts 2003, No. 456, §§1 and 2.

§1408. Disapproval of filings

A. If within the waiting period or any extension thereof as provided in R.S. 22:1407(D), the commission finds that a filing does not meet the requirements of this Part, it shall send to the insurer or rating organization which made such filings written notice of disapproval of such filing specifying wherein it finds such filing fails to meet the requirements of this Part and stating that such filing shall not become effective.

B. If within thirty days after a specific inland marine rate on a risk specially rated by a rating organization subject to R.S. 22:1407(E) has become effective, the commission finds that such filing does not meet the requirements of this Part, it shall send to the insurer or rating organization which made such filing written notice of disapproval of such filing, specifying wherein it finds that such filing fails to meet the requirements of this Part and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. Said disapproval shall not affect any contract made or issued prior to the expiration of the period set forth in said notice.

C. If at any time subsequent to this applicable review period provided for in Subsection A or B of this Section, or after a filing has become effective under R.S. 22:1407(F), the office of property and casualty finds that a filing does not meet the requirements of this Part, it shall request a hearing to be held before the commission upon not less than ten days' written notice, specifying the matters to be considered at such hearing to every insurer and rating organization which made such filing, and the commission shall thereafter issue an order specifying in what respects, if any, the commission finds that such filing fails to meet the requirements of this Part, and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. Copies of said order shall be sent to every such insurer and rating organization. Said order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in said order.

D.(1) Any person or organization aggrieved with respect to any filing which is in effect may make written application to the commission for a hearing thereon; however, the insurer or rating organization that made the filing shall not be authorized to proceed under this Subsection. Such application shall specify the grounds to be relied upon by the applicant. If the commission shall find that the application is made in good faith, that the applicant would be so aggrieved if his grounds are established, and that such grounds otherwise justify holding such a hearing, it shall within thirty days after receipt of such application hold a hearing upon not less than ten days' written notice to the applicant and to every insurer and rating organization which made such filing.

(2) If, after such hearing, the commission finds that the filing does not meet the requirements of this Part, it shall issue an order specifying in what respect the commission finds that such filing fails to meet the requirements of this Part, and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. Copies of said order shall be sent to the applicant and to every such insurer and rating organization. Said order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in said order.

Acts 1958, No. 125; Acts 1960, No. 296, §1; Acts 1966, No. 136, §1; Acts 2003, No. 456, §1.

§1409. Other rating organizations

A. A corporation, an unincorporated association, a partnership, or an individual, whether located within or outside this state, may make application to the commission for license as a rating organization for such kinds of insurance, or subdivision, or class of risk, or a part or combination thereof as are specified in its application and shall file therewith (1) a copy of its constitution, its articles of agreement or association, or its certificate of incorporation, and of its bylaws, rules, and regulations governing the conduct of its business, (2) a list of its members and subscribers, (3) the name and address of a resident of this state upon whom notices or orders of the commission or a division or process affecting such rating organization may be served, and (4) a statement of its qualifications as a rating organization. If the commission finds that the applicant is competent, trustworthy, and otherwise qualified to act as a rating organization and that the public interest would be served by issuing a license to such organization, not heretofore licensed, for a kind or class of insurance subject to this Part, and that its constitution, articles of agreement or association, or certificate of incorporation, and its bylaws, rules, and regulations governing the conduct of its business conform to the requirements of law, the commission shall issue a license specifying the kinds of insurance, or subdivision, or class of risk, or part or combination thereof for which the applicant is authorized to act as a rating organization. Every such application shall be granted or denied in whole or in part by the commission within sixty days of the date of its filing with it. Licenses issued pursuant to this Section shall remain in effect for three years unless sooner suspended or revoked by the commission. Licenses issued pursuant to this Section may be suspended or revoked by the commission after hearing upon notice, in the event the rating organization ceases to meet the requirements of this Subsection. Every rating organization shall notify the commission promptly of every change in (1) its constitution, its articles of agreement, or association, or its certificate of incorporation, and its bylaws, rules, and regulations governing the conduct of its business, (2) its list of members and subscribers, and (3) the name and address of the resident of this state designated by it upon whom notices or orders of the commission or process affecting such rating organization may be served.

B. Subject to rules and regulations which have been approved by the commission as reasonable, each rating organization, including the Property Insurance Association of Louisiana, shall permit any insurer not a member to be a subscriber to its rating services for any kind of insurance, subdivision, or class of risk or a part or combination thereof for which it is authorized to act as a rating organization. Notice of proposed changes in such rules and regulations shall be given to subscribers. Each rating organization shall furnish its rating services without discrimination to its members and subscribers. The reasonableness of any rule or regulation in its application to subscribers, or the refusal of any rating organization to admit an insurer as a subscriber, shall, at the request of any subscriber or any such insurer, be reviewed by the commission at a hearing held upon at least ten days' written notice to such rating organization and to such subscriber or insurer. If the commission finds that such rule or regulation is unreasonable in its application to subscribers, the commission shall order that such rule or regulation shall not be applicable to subscribers. If the rating organization fails to grant or reject an insurer's application for subscribership within thirty days after it was made, the insurer may request a review by the commission as if the application had been rejected. If the commission finds that the insurer has been refused admittance to the rating organization as a subscriber without justification, the commission shall order the rating organization to admit the insurer as a subscriber. If the commission finds that the action of the rating organization was justified, it shall make an order affirming its action.

C. No rating organization shall adopt any rule the effect of which would be to prohibit or regulate the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

D. Cooperation among rating organizations or among rating organizations and insurers in ratemaking or in other matters within the scope of this Part is hereby authorized, provided the filings resulting from such cooperation are subject to all the provisions of this Part which are applicable to filing generally. The commission may review such cooperative activities and practices and if, after a hearing, it finds that any such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this Part, the commission shall issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this Part, and requiring the discontinuance of such activity or practice.

E. Any rating organization may provide for the examination of policies, daily reports, binders, renewal certificates, endorsements, or other evidences of insurance, or the cancellation thereof, and may make reasonable rules governing their submission. Such rules shall contain a provision that in the event any insurer does not within sixty days furnish satisfactory evidence to the rating organization of the correction of any error or omission previously called to its attention by the rating organization it shall be the duty of the rating organization to notify the Louisiana Insurance Rating Commission thereof. No such notification need be furnished the Louisiana Insurance Rating Commission unless it is apparent that a hearing will be required. All information so submitted for examination shall be confidential.

F. Any rating organization may subscribe for or purchase actuarial, technical, or other services, and such services shall be available to all members and subscribers without discrimination.

G.(1) Notwithstanding any contrary provision of this Title, a rating organization shall make informational filings only and shall not promulgate rates, except as otherwise provided in this Subsection, or as designated or authorized by the Louisiana Insurance Rating Commission because of lack of credibility of data in the statistical base. All such filings shall be subject to actuarial interpretation by the Louisiana Insurance Rating Commission and shall in no case include specific rates. Each insurer who is a subscriber to a rating organization shall file its rates individually.

(2) The following associations shall be authorized to make filings, including rate filings, for their members:

(a) The Property Insurance Association of Louisiana.

(b) The Louisiana Automobile Insurance Plan.

(c) The Louisiana Joint Reinsurance Association (FAIR plan).

(d) The Louisiana Insurance Underwriting Association (Coastal plan).

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1; Acts 1986, No. 37, §1, eff. June 13, 1986; Acts 1988, No. 357, §1, eff. Sept. 1, 1988; Acts 2003, No. 456, §1.

§1410. Deviations

A. Every member of or subscriber to the Property Insurance Association of Louisiana or other rating organization shall adhere to the rates and filings made on its behalf by such organization, except that:

(1) In case of fire, marine, and inland marine insurance to which this Part applies, any insurer may make written application to the commission for permission to file a deviation from the class rates, schedules, rating plans or rules respecting any kind of insurance, or class of risk within a kind of insurance or combination thereof. Such application shall specify the basis for the modification, and a copy thereof shall also be sent simultaneously to such rating organization concerned.

(2) In the case of casualty insurance to which this Part applies, any insurer may make written application to the commission for permission to file a uniform percentage decrease or increase to be applied to the premiums produced by the rating system prescribed or permitted by the commission for a kind of insurance, or for a class of insurance which is found by the commission to be a proper rating unit for the application of such uniform percentage decrease or increase, or for a subdivision of a kind of insurance (a) comprised of a group of manual classifications which is treated as a separate unit for rate-making purposes, or (b) for which separate expense provisions are included in the rating system prescribed or permitted by the commission. Such application shall specify the basis for the modification and shall be accompanied by the data upon which the applicant relies.

B. The office of property and casualty shall place all such applications for deviations on the agenda for a regularly scheduled meeting of the commission. The commission shall issue an order permitting the modification for such insurer to be filed if it finds it to be justified, and it shall thereupon become effective. It shall issue an order denying such application if it finds that the modification is not justified or that the resulting premiums would be excessive, inadequate, or unfairly discriminatory. The insurer so denied by the commission may then apply to the commission for a hearing thereon. Each deviation permitted to be filed shall be effective for a period of one year from the date of such permission unless terminated sooner with the approval of the commission.

C. In considering the application for permission to file such deviation in the case of fire, marine, and inland marine insurance, the commission shall give consideration to the available statistics and the applicable principles for ratemaking as provided in R.S. 22:1404. The commission shall approve such application if the rate sought to be used meets the requirements of R.S. 22:1404(3).

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1; Acts 1966, No. 136, §1; Acts 2003, No. 456, §1.

§1411. Appeal

Any member of or subscriber to a rating organization may appeal to the commission from the action or decision of such rating organization in approving or rejecting any proposed change in or addition to the filings of such rating organization. The commission shall, after a hearing held upon not less than ten days' written notice to the appellant and to such rating organization, issue an order approving the action or decision of such rating organization or directing it to give further consideration to such proposal, or, if such appeal is from the action or decision of the rating organization in rejecting a proposed addition to its filings, it may, in the event the commission finds that such action or decision was unreasonable, issue an order directing the rating organization to make an addition to its filings, on behalf of its members and subscribers, in a manner consistent with the findings of the commission within a reasonable time after the issuance of such order.

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1; Acts 2003, No. 456, §1.

§1412. Information to be furnished insureds; hearings and appeals of insureds

A. Every rating organization and every insurer which makes its own rates shall, within a reasonable time after receiving written request therefor and upon payment of such reasonable charge as it may make, furnish to any insured affected by a rate made by it, or to the authorized representative of such insured, all pertinent information as to such rate.

B. Every rating organization and every insurer which makes its own rates shall provide within this state reasonable means whereby any person aggrieved by the application of its rating system may be heard in person or by his authorized representative, on his written request to review the manner in which such rating system has been applied in connection with the insurance afforded him. If the rating organization or insurer fails to grant or reject such request within thirty days after it is made, the applicant may proceed in the same manner as if his application had been rejected. Any party affected by the action of such rating organization or such insurer, except for a worker's compensation insurer, on such request may, within thirty days after written notice of such action, appeal to the Louisiana Insurance Rating Commission, which, after a hearing held upon not less than ten days' written notice to the appellant and to such rating organization or insurer, may affirm or reverse such action. Except as provided in R.S. 23:1395(A), any party affected by the action of a worker's compensation insurer may appeal in accordance with the procedures adopted by the Louisiana Insurance Rating Commission and thereafter to the Nineteenth Judicial District Court in accordance with the provisions of the Louisiana Code of Civil Procedure. In the event that this Section is in conflict with R.S. 23:1395(A), the provisions of R.S. 23:1395(A) shall control.

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1; Acts 1993, No. 547, §1.

§1413. Advisory organizations

A. Every group, association, or other organization of insurers, whether located within or outside this state, which assists insurers which make their own filings or rating organization or any division in rate making, by the collection and furnishing of loss or expense statistics or by the submission of recommendations, but which does not make filings under this Part, shall be known as an advisory organization.

B. Every advisory organization shall file with the commission (1) a copy of its constitution, its articles of agreement or association, or its certificate of incorporation and of its bylaws, rules, and regulations governing its activities, (2) a list of its members, (3) the name and address of a resident of this state upon whom notices or orders of the commission, or the office of property and casualty, or process issued at the direction of the commission may be served, and (4) an agreement that the commissioner of insurance may examine such advisory organization in accordance with the provisions of Part XXVIII.[1]

C. If after a hearing, the commission finds that the furnishing of such information or assistance involves any act or practice which is unfair or unreasonable or otherwise inconsistent with the provisions of this Part, the commission shall issue a written order specifying in what respects such act or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this Part, and requiring the discontinuance of such act or practice.

D. No insurer which makes its own filings nor any rating organization shall support its filings by statistics or adopt rate-making recommendations, furnished to it by an advisory organization which has not complied with this Section or with an order of the commission involving such statistics or recommendations issued under Subsection C of this Section. If the commission finds such insurer or advisory organization to be in violation of this Subsection, it may issue an order requiring the discontinuance of such violation.

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1; Acts 2003, No. 456, §1.

[1]R.S. 22:1301 to 22:1314

§1414. Joint underwriting or joint reinsurance

A. Every group, association or other organization of insurers which engages in joint underwriting or joint reinsurance, shall be subject to regulations with respect thereto as herein provided, subject, however, with respect to joint underwriting, to all other provisions of this Part, and with respect to joint reinsurance, to R.S. 22:1416, Part XXVIII,[1] and to the penalties provided for violation of this Part.

B. If, after a hearing, the commission finds that any activity or practice of any such group, association, or other organization is unfair or unreasonable or otherwise inconsistent with the provisions of this Part, the commission shall issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this Part, and requiring the discontinuance of such activity or practice.

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1; Acts 2003, No. 456, §1.

[1]R.S. 22:1301 et seq.

§1415. Rate administration

A. Recording and reporting of loss and expense experience. The commission shall promulgate reasonable rules and statistical plans, reasonably adapted to each of the rating systems on file with the commission, which may be modified from time to time and which shall be used thereafter by each insurer in the recording and reporting of its loss and countrywide expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid the office of property and casualty and the commission in determining whether rating systems comply with the standards set forth in R.S. 22:1404. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state and are not susceptible of determination by a prorating of countrywide expense experience. In promulgating such rules and plans, the commission shall give due consideration to the ratings systems on file with the commission and, in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it. The commission may designate one or more rating organizations or other agencies to assist it in gathering such experience and making compilations thereof, and such compilations shall be made available, subject to reasonable rules promulgated by the commission, to insurers and rating organizations.

B. Interchange of rating plan data. Reasonable rules and plans may be promulgated by the commission for the interchange of data necessary for the application of rating plans.

C. Consultation with other states. In order to further uniform administration of rate regulatory laws, the commission, the office of property and casualty, and every insurer and rating organization may exchange information and experience data with insurance supervisory officials, insurers, and rating organizations in other states and may consult with them with respect to ratemaking and the application of rating systems.

D. Rules and regulations. The commission may make reasonable rules and regulations necessary to effect the purposes of this Part, but no such rule or regulation shall unfairly discriminate against any insurer on account of its plan of operation or otherwise, regardless of whether or not any such insurer is a member of a rating organization.

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1; Acts 1989, No. 346, §1; Acts 1991, No. 1026, §2; Acts 2003, No. 456, §1.

§1416. False or misleading information

No person or organization shall willfully withhold information from or knowingly give false or misleading information to the commission, the office of property and casualty, any statistical agency designated by him, any rating organization, or any insurer which will affect the rates or premiums chargeable under this Part. A violation of this Section shall subject the one guilty of such violation to the penalties provided for violation of this Part.

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1; Acts 2003, No. 456, §1.

§1417. Assigned risks; governing committee

A. With respect to casualty insurance to which this Part applies, agreement may be made among insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to, but who are unable to procure such insurance through ordinary methods, and such insurers may agree among themselves on the use of reasonable rate modifications for such insurance, such agreements and rate modifications to be subject to the approval of the Louisiana Insurance Rating Commission. No domestic insurance company shall be denied servicing carrier status.

B. Effective on August 15, 1993, the governing committee of the assigned risks, or "Louisiana Automobile Insurance Plan", shall consist of the following nine members:

(1) One member shall be the commissioner of insurance or his designee.

(2) One member shall be a representative designated by the Louisiana Insurance Rating Commission.

(3) One member shall be a representative designated by the Louisiana Association of Fire and Casualty Insurance Companies.

(4) One member shall be appointed by the president of the Senate.

(5) One member shall be appointed by the speaker of the House of Representatives.

(6) The remaining four members shall consist of representatives selected from and by the membership subject to final approval by the commissioner of insurance.

C. Every insurer under this Section shall maintain an office in this state for the purpose of processing claims on property and casualty insurance policies issued or delivered by the insurer in this state of claims of the assigned risk pool. In lieu of maintaining a claims adjuster for processing claims on property and casualty insurance policies issued or delivered by the insurer in the state, the insurer shall file with the commissioner the address and telephone number of the claims office of the insurer located in the state or the name, address, and telephone number of the claims adjuster retained by the insurer in the state.

D. Each claims office or claims adjuster retained by such insurer shall maintain, on computer or otherwise, claims submitted to the property and casualty insurer, for six months after the claim is finally resolved or for six months after expiration of prescription of a claim, whichever occurs first. Personnel in the claims office or the adjuster, if retained, shall be authorized by the insurer to issue checks, settle claims, and contravene on behalf of the insurer concerning claims made to that office or adjuster on policies issued or delivered by the property and casualty insurer.

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1. Acts 1985, No. 644, §1; Acts 1986, No. 1021, §1; Acts 1993, No. 599, §1.

§1417.1. REPEALED BY ACTS 2003, No. 456, §2.

§1418. Hearing procedure

Any insurer or rating organization aggrieved by any order or decision of the commission made without a hearing may, within thirty days after notice of the order to the insurer or organization, make written request to the commission for a hearing thereon. Any hearing under this Part and any review of any action taken by the commission shall be in conformity with the procedure set forth in Part XXIX.[1]

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1; Acts 2003, No. 456, §1.

[1]R.S. 22:1351 to 22:1366

§1419. Assessments against insurers; dedications

A.(1) Sufficient funds determined by the commission shall be provided by all insurers doing business in this state and subject to this Part, by the payment of an assessment to be levied against them by the commission in proportion to their gross direct premiums received in this state in the preceding year, less returned premiums. No such assessment shall exceed one percent of such premiums.

(2) An amount equal to two and one-fourth hundredths of one percent of the gross direct premiums received in this state, in the preceding year; two and thirty-seven hundredths of one percent of the direct gross premiums received in this state, in the year 2001; and two and one-half hundredths of one percent of the direct gross premiums received in the state, in the year 2003 and every year thereafter by insurers doing business in this state and subject to this Part, less returned premiums shall be deposited by the commission with the state treasurer to be credited to a special fund created in the state treasury entitled the Municipal Fire and Police Civil Service Operating Fund, hereinafter known as the "fund". Subject to an annual appropriation by the legislature pursuant to the provisions of R.S. 33:2480 and 2540, monies in the fund shall be used solely to support the operations of the office of state examiner, Municipal Fire and Police Civil Service. Monies in the fund shall be invested by the treasurer in the same manner as monies in the state general fund and interest earned on investment of these monies shall be credited to the state general fund. All unexpended and unencumbered monies in the fund at the end of the fiscal year shall revert to the state general fund.

(3) Regardless of the percentage assessed by the commission, an amount equal to seven-tenths of one percent of the gross direct premiums received in this state, in the preceding year, by insurers doing business in this state and subject to this Part, less returned premiums shall be deposited by the commission with the state treasurer on behalf of the Municipal Police Employees' Retirement System, the Sheriffs' Pension and Relief Fund, and the Firefighters' Retirement System for the exclusive use of these retirement systems and allocated as follows:

(a)(i) First, the assessment shall be used for funding of mergers of local retirement systems with these statewide retirement systems, such mergers to be funded over a period of thirty years, unless the Public Retirement Systems' Actuarial Committee deems a shorter period appropriate. Such shorter period shall not use more than five percent of the total assessment in any one year, nor shall the aggregate of all mergers being funded in any one year use more than twenty-five percent of the total assessment in any one year.

(ii) One million five hundred thousand dollars of the twenty-five percent of the total assessment which is allocated for the purpose of mergers shall be expended first to fund the annual actuarial cost incurred by the State Police Pension and Retirement System with regard to implementation of Acts 2001, No. 1160, and this one million five hundred thousand dollars shall be expended prior to the funding of any mergers.

(b)(i) Second, any funds that remain after the allocations provided for in Subparagraph (a) of this Paragraph shall be used as provided for in Item (ii) of this Subparagraph, in meeting the remaining portion of the actuarially required contributions after receipt of the employee contributions at the rate established in R.S. 11:62(3), (6), and (9), after receipt of the employer contributions at the rate established in R.S. 11:103(C), and after receipt of all dedicated funds and taxes referred to in R.S. 11:103(C)(2)(a), in the amounts determined by the Public Retirement Systems' Actuarial Committee.

(ii)(aa) Any funds that remain after the allocations provided for in Subparagraph (3)(a) of this Paragraph shall be divided into three thirds and, then, a one-third portion shall be allocated separately to each of the three systems. Except as otherwise provided in this Item, each such system shall not receive a greater portion than one-third.

(bb) It is hereby acknowledged that any one system may not need the entire one-third portion that it receives each year to meet the remaining portion of its actuarially required contributions. In that event, any unused allocated funds shall be reallocated to such other system or systems of the three systems that have a need for additional funds to meet the remaining portion of the actuarially required contributions.

(cc) If one system does not need its total annual allocated portion, but two other systems do use their total annual allocated portions to meet the remaining portion of the actuarially required contributions and need additional funds for that purpose, then the unused allocated portion of the system that did not use its total annual allocated portion shall be divided equally between the two systems that need additional funds to meet the remaining portion of their actuarially required contributions, except that any funds not needed by either such system shall be reallocated to the other such system to meet the remaining portion of the actuarially required contributions.

(dd) Funds that are reallocated to a system pursuant to Subitem (bb) or (cc) of this Item shall be limited to the amount that is necessary to meet the remaining portion of the actuarially required contributions of the receiving system.

(c) The phrase "retirement system" or "system" as used in Paragraphs (3), (4), and (5) of this Subsection shall include the Sheriffs' Pension and Retirement Fund, as applicable, notwithstanding that it is technically a retirement fund and not a retirement system.

(4) After payment of the amounts established by the Public Retirement Systems' Actuarial Committee to the retirement systems as provided for in Paragraph (3) of this Subsection, all remaining funds shall be remitted to the state general fund.

(5) Any insurer which has not had one full year of experience immediately preceding said assessment, shall pay a sum to be fixed by the commission, and the following years its proportion shall be based upon its estimated premiums for the current year, subject to revision at the end of the year in accordance with the gross premiums received by said insurer, as hereinabove provided.

B. The expenses of the commission shall be met by an annual assessment on each insurer subject to this part on the direct premiums, less return premiums, developed by it from the rates subject to regulation. The amount of such assessment shall be determined by the commission, but no such assessment shall exceed one percent of such premiums.

C. The expense fund so created shall be subject to the sole control of the commission, but shall be subject to budgetary controls as authorized in Title 39 of the Louisiana Revised Statutes of 1950; provided, however, that all surplus funds presently in said fund shall be immediately remitted to the general fund of the state and provided further that all surplus funds at the end of each fiscal year hereafter shall be remitted to the general fund of the state.

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1; Acts 1962, No. 10, §1; Acts 1972, No. 119, §1; Acts 1973, No. 188, §1; Acts 1974, No. 323, §1; Acts 1979, No. 434, §2; Acts 1980, No. 799, §4, eff. Aug. 1, 1980; Acts 1991, No. 397, §2, eff. July 1, 1991; Acts 1992, No. 497, §1, eff. July 1, 1992; Acts 1999, No. 931, §1; Acts 2001, No. 1160, §2, eff. July 1, 2001; Acts 2003, No. 456, §1.

§1420. REPEALED BY ACTS 2003, No. 456, §2.

§1421. Public property rates

The rates of fire, windstorm, and hail insurance covering state, parochial, and municipal public buildings or other public property shall be subject to supervisory and experience credits as promulgated by the Property Insurance Association of Louisiana.

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1; Acts 1985, No. 228, §1.

§1422. Right to employ attorney

In the event the commission or the office of property and casualty deems it necessary to take any legal step or to file any suit or other proceedings to carry out the provisions of this Part, they shall have the right to employ an attorney for said purpose, provided the fees to be paid said attorney shall be approved by the attorney general. It shall be the duty of the attorney general to render advice to the commission and the office of property and casualty upon request.

Acts 1958, No. 125. Amended by Acts 1960, No. 296, §1; Acts 2003, No. 456, §1.

§1422.1. Consumer representation; attorney general

In all proceedings before the Insurance Rating Commission, the attorney general shall have the right to represent the interest of the people of the state of Louisiana. The attorney general, or his designee, shall have the right to question witnesses, including industry or company representatives and all others appearing before the commission, and shall have the right to issue subpoenas to compel the attendance of witnesses and the production of documents.

Acts 1986, No. 834, §1.

§1423. Worker's compensation insurers; longshoremen and harbor worker's compensation insurers; annual reports

A. The Louisiana Insurance Rating Commission, hereafter referred to as the "commission", shall promulgate rules and regulations which shall require each insurer licensed to write worker's compensation insurance in this state, as a supplement to Schedule T of its annual statement, to submit a report by May 1 of each year showing its direct writings in this state. The commission shall furnish the form. The commission shall designate one or more rate service organizations to gather and compile such experience and data.

B. The commission shall also promulgate rules and regulations which require each insurer licensed to write longshoremen and harbor worker's compensation insurance in this state, as a supplement to Schedule T of its annual statement, to submit a report by May 1 of each year showing its direct writings in this state. The commission shall furnish the form. The commission may designate one or more rate service organizations to gather and compile such experience and data.

C. The supplemental reports required by Subsections (A) and (B) of this Section shall include the following data for the previous year ending on the thirty-first day of December:

(1) Direct premiums written.

(2) Direct premiums earned.

(3) Net investment income, including net realized capital gains and losses, using appropriate estimates where necessary.

(4) Incurred claims developed as the sum of, and with figures provided for, the following:

(a) Dollar amount of claims closed with payment, plus

(b) Reserves for reported claims at the end of the current year, minus

(c) Reserves for reported claims at the end of the previous year, plus

(d) Reserves for incurred but not reported claims at the end of the current year, minus

(e) Reserves for incurred but not reported claims at the end of the previous year, plus

(f) Dollar amounts of payments for loss of adjustment expense, plus

(g) Reserves for loss adjustment expense at the end of the current year, minus

(h) Reserves for loss adjustment expense at the end of the previous year.

(5) Incurred expenses, actual when possible and estimated otherwise, allocated separately to commissions, other acquisition costs, general expenses, licenses and fees, and all other expenses.

(6) Net underwriting gain or loss.

(7) Net operation gain or loss, including net investment income.

(8) Any other related information requested by the commission.

D. For the first year only in which the insurer shall be required to file this supplemental report, the data required by Paragraphs (1) through (7) of Subsection (C) of this Section shall include the previous calendar year and each of the preceding four calendar years.

E. The commission shall annually compile and review all reports submitted by insurers pursuant to this Section for the purpose of facilitating the determination of the appropriateness of premium rates for worker's compensation insurance in this state and for longshoremen's and harbor worker's compensation insurance in this state. The commission's findings and the filings shall be published and made available to any interested insured or citizen and shall be retained by the commission for a period of not less than ten years.

F. All rules and regulations shall be promulgated in accordance with the Administrative Procedure Act.

Added by Acts 1983, 1st Ex. Sess., No. 1, §2, eff. July 1, 1983.

§1424. Worker's compensation rates; safe workplace discount; criteria; inspection

A. Any insurer submitting rates and rating plans under this Part for worker's compensation policies may, but shall not be required to, provide for a safe workplace discount on worker's compensation premiums for those Louisiana employers who meet criteria, as established by the commissioner, to promote and maintain safety in the workplace. Such discount shall not exceed twenty percent of the amount of the premium.

B. The commissioner may promulgate rules and regulations specifying criteria for the safe workplace discount. He may also promulgate rules and regulations providing for an inspection program to establish the eligibility of any employer for a safe workplace discount, the premium volume to qualify, and the percent of discount available to eligible employers.

C. Any rules and regulations promulgated to provide for a safe workplace discount under the provisions of this Section shall become effective no later than July 1, 1990.

Acts 1989, No. 664, §1.

§1425. Military personnel premium discount; rebates

A.(1) Beginning on July 1, 2005 and until July 1, 2006, every motor vehicle insurer authorized to transact business in this state shall provide to active military personnel based in this state a discount of twelve and one-half percent of the premium on any automobile liability insurance policy purchased in this state to cover motor vehicles owned by such military personnel.

(2) Beginning on July 1, 2006 and thereafter, every motor vehicle insurer authorized to transact business in this state shall provide to active military personnel based in this state a discount of twenty-five percent of the premium on any automobile liability insurance policy purchased in this state to cover motor vehicles owned by such military personnel.

B. Insurers providing the discount authorized by this Section to active military personnel shall be entitled to a credit that shall be applied toward the premium taxes imposed under R.S. 22:1061 and 1065 in an amount equal to the discount actually provided. To the extent an insurer's credit authorized in this Section exceeds the insurer's premium tax liability, the amount of credit not used to offset premium taxes due shall be considered overpaid taxes and shall be refundable to the insurer, without interest. Such insurers shall submit to the commissioner of insurance the documents, evidence, and proof required, in accordance with the rules and regulations adopted by the commissioner, to establish the discounts actually provided.

C. The commissioner of insurance shall adopt rules and regulations, in accordance with the Administrative Procedure Act, to implement the provisions of this Section. The rules and regulations shall include and not be limited to the following:

(1) Provisions defining and delineating active military personnel who may receive the discount.

(2) Recordkeeping requirements for the insurers.

(3) Procedures for submitting claims for premium tax credits.

(4) A listing of the documents, evidence, and proof necessary to establish a valid claim.

(5) Time requirements and limitations for the submission of a claim, examination of the claim, and a final decision by the commissioner.

(6) Other such provisions necessary for the proper implementation of this Section.

Added by Acts 2004, No. 770, §1; Acts 2005, No. 408, §1, eff. July 11, 2005.

§§1426. – §1430. [Blank]

SUBPART B. LOUISIANA CITIZENS PROPERTY INSURANCE CORPORATION

§1430. Louisiana Citizens Property Insurance Corporation; declaration and purpose; construction

It is hereby declared by the Legislature of Louisiana that an adequate market for fire with extended coverage and vandalism and malicious mischief insurance and homeowners coverage is necessary to the economic welfare of the state, including the coastal areas of the state, and that without such insurance the orderly growth and development of the state would be severely impeded; and that adequate insurance upon property is necessary to enable owners of homes and commercial owners to obtain financing for the purchase and improvement of their property. It is further declared that the state has an obligation to provide an equitable method whereby every licensed insurer writing fire, extended coverage and vandalism and malicious mischief and, if necessary, homeowners coverage on a direct basis in Louisiana is required to meet its public responsibility instead of shifting the burden to a few willing and public-spirited insurers. While deserving praise, the financing mechanisms of the former plans were insufficient to meet the needs of this area. It is the purpose of this Subpart to accept this obligation and to provide a mandatory program to assure an adequate market for fire, extended coverage and vandalism and malicious mischief and, if necessary, homeowners insurance in the coastal and other areas of Louisiana. The legislature intends by this Subpart that property insurance be provided and that it continues, as long as necessary, through an entity organized to achieve efficiencies and economies, all toward the achievement of the foregoing public purposes. Therefore, the Louisiana Citizens Property Insurance Corporation, a nonprofit corporation, is hereinafter created, and said corporation shall operate insurance plans which shall function exclusively as residual market mechanisms to provide essential property insurance for residential and commercial property, solely for applicants who are in good faith entitled, but are unable, to procure insurance through the voluntary market. The legislature further intends that the corporation work toward the ultimate depopulation of these residual market insurance plans. Because it is essential for the corporation to have the maximum financial resources to pay claims following a catastrophic hurricane, it is the intent of the legislature that the income of the corporation be exempt from federal income taxation and that interest on the debt obligations issued by the corporation be exempt from federal income taxation.

Acts 2003, No. 1133, §1.

§1430.1. Definitions

As used in this Subpart, unless the context otherwise requires:

(1) "Assessable insureds" means insureds who procure a policy of insurance for one or more subject lines of business in this state.

(2) "Assessable insurers" means insurers authorized to write one or more subject lines of business in this state.

(3) "Coastal area" means all of that area of the state designated in the plan of operation submitted by the governing board, approved by the Louisiana Insurance Rating Commission and designated as Coastal Plan (Louisiana Insurance Underwriting Plan) area.

(4) "Coastal Plan" means the successor to that program established by Act 35 of the 1970 Regular Session to provide a residual market for adequate insurance on property in the coastal areas of the state, now available as a program of the Louisiana Citizens Property Insurance Corporation.

(5) "Corporation" means the Louisiana Citizens Property Insurance Corporation, and includes the residual market insurance programs known as the "Coastal Plan" and the "FAIR Plan".

(6) "Essential property insurance" means any of the following coverages against direct loss to property as defined by the plan of operation approved by the Louisiana Insurance Rating Commission:

(a) Fire, with or without extended coverage and vandalism and malicious mischief.

(b) Windstorm and hail without fire, but only with respect to dwellings and commercial properties on a monoline basis.

(c) Homeowners.

(7) "FAIR Plan" means the successor to that program established by Act 424 of the 1992 Regular Session, and designated as the "Fair Access to Insurance Requirements Plan" to provide a residual market for adequate insurance on property in the state, now available as a program of the Louisiana Citizens Property Insurance Corporation.

(8) "Governing board" means that board of directors which is established under R.S. 22:1430.3 and, where appropriate, any designee of the governing board.

(9) "Insurable property" means real and tangible personal property at a fixed location in Louisiana when such property is in an insurable condition and basic property insurance is not obtainable in the voluntary market and as further defined by the governing board.

(10) "Net direct premiums" means gross direct premiums, excluding reinsurance assumed, written for subject lines of business, less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits. In no event shall premiums on industrial fire insurance policies be considered as net direct premiums.

(11) "Plan of operation" means the document setting the rules of operation of the corporation, as promulgated by the governing board and approved by the Louisiana Senate Committee on Insurance and the Louisiana House Committee on Insurance pursuant to the provisions of this Subpart.

(12) "Subject lines of business" means the following lines of business: fire, allied lines, homeowners multiperil, and the property insurance portion of commercial multiperil policies.

Added by Acts 2003, No. 1133, §1; Acts 2004, No. 106, §1.

§1430.2. Creation of the Louisiana Citizens Property Insurance Corporation

A. There is created a nonprofit corporation to be known as the "Louisiana Citizens Property Insurance Corporation", which shall operate residual market insurance programs, designated as the Coastal Plan and the FAIR Plan, sometimes hereinafter referred to as "the plans", as successors to the Louisiana Insurance Underwriting Plan (Coastal Plan) and the Louisiana Joint Reinsurance Plan (FAIR Plan); and whose domicile for purpose of suit shall be East Baton Rouge Parish, Louisiana. All insurers authorized to write, and engaged in writing, property insurance in the state of Louisiana shall participate in the Coastal Plan and the FAIR Plan as a condition of their authority to transact insurance in this state. The corporation shall perform its functions under a plan of operation established and approved under R.S. 22:1430.7 and shall exercise its powers through a board of directors established under R.S. 22:1430.3.

B.(1) Assets of the corporation shall not be considered part of the general fund of the state. The state shall not budget for or provide general fund appropriations to the corporation, and the debts, claims, obligations, and liabilities of the corporation shall not be considered to be a debt of the state or a pledge of its credit.

(2) The corporation shall be prohibited from making contributions to any political party, political organization, public official, or candidate for public office, whether federal, state or local in nature.

(3) All compensated employees of the corporation shall be subject to the provisions of Article X, Part I, Section 9 of the Louisiana Constitution of 1974, "Prohibitions Against Political Activities", as if they were employees of the state, except members of the governing board of the corporation.

C. Neither the corporation nor the plans shall be required to obtain a certificate of authority from the commissioner of insurance, nor shall they participate in the Louisiana Insurance Guaranty Association.

D.(1) Notwithstanding the provisions of Subsections A and B of this Section, and except as provided by Paragraph (2) of this Subsection, the corporation shall be subject to R.S. 42:4.1 through 13 and to R.S. 44:1 through 41, and may be considered as if it were a public body for the purpose of those provisions.

(2) The corporation may hold an executive session pursuant to R.S. 42:6 for discussion of one or more of the following, and R.S. 44:1 through 41 shall not apply to any documents as enumerated in R.S. 44:1(A)(2) which relate to one or more of the following:

(a) Underwriting files, except that a policyholder or an applicant shall have access to his or her own underwriting files.

(b) Claims files, until termination of all litigation and settlement of all claims arising out of the same incident, although portions of the claims files may remain exempt, as otherwise provided by law. Confidential and exempt claims file records may be released to other governmental agencies upon written request and demonstration of need; such records held by the receiving agency remain confidential and exempt as provided for herein.

(c) Records obtained or generated by an internal auditor pursuant to a routine audit, until the audit is completed, or if the audit is conducted as part of an investigation, until the investigation is closed or ceases to be active. An investigation is considered "active" while the investigation is being conducted with a reasonable, good faith belief that it could lead to the filing of administrative, civil, or criminal proceedings.

(d) Matters reasonably encompassed in privileged attorney-client communications.

(e) Proprietary information licensed to the corporation, or either of the plans prior to enactment of this Subpart, under contract, where the contract provides for the confidentiality of such proprietary information.

(f) All information relating to the medical condition or medical status of a corporation employee which is not relevant to the employee's capacity to perform his or her duties, except as otherwise provided in this Paragraph. Information which is exempt shall include but is not limited to information relating to workers' compensation, insurance benefits, and retirement or disability benefits.

(g) Upon an employee's entrance into an employee assistance program, a program to assist any employee who has a behavioral or medical disorder, substance abuse problem, or emotional difficulty which affects the employee's job performance, all records relative to that participation shall be confidential.

(h) Information relating to negotiations for financing, reinsurance, depopulation, or contractual services, until the conclusion of the negotiations.

(i) Minutes of closed meetings regarding underwriting files and minutes of closed meetings regarding an open claims file until termination of all litigation and settlement of all claims with regard to that claim, except that information otherwise confidential or exempt by law will be redacted.

(3) When an authorized insurer is considering underwriting a specific risk insured by the corporation, relevant underwriting files and confidential claims files may be released to the insurer provided the insurer agrees in writing, notarized and under oath, to maintain the confidentiality of such files. When a file is transferred to an insurer that file is no longer a public record because it is not held by an agency subject to the provisions of the public records law. Notwithstanding the provisions of this Subsection, the corporation shall not provide either a partial or complete list of the plans' insureds, applicants or claimants to any voluntary insurer.

Acts 2003, No. 1133, §1.

§1430.3. Board of directors of corporation

A. The governing body of the corporation shall be a board of directors which shall consist of the following members, who shall be representative of the state's population as near as practicable:

(1) The commissioner of the Department of Insurance, or an employee of the Department of Insurance as his designee.

(2) The state treasurer, or an employee of the Department of the Treasury as his designee.

(3) The chairman of the House Committee on Insurance, or a member of that committee designated by the chairman.

(4) The chairman of the Senate Committee on Insurance, or a member of that committee designated by the chairman.

(5) Five representatives appointed by the governor, one from a list of two nominees from the domestic insurer with the largest direct written premium in the state of the subject lines of business; one from a list of two nominees from an insurer with at least one percent of the aggregate statewide direct written premium of the subject lines of business; and the remaining three representatives shall be appointed at large.

(6) One member appointed by the commissioner from a list of three nominees from the Professional Insurance Agents of Louisiana, or its successor.

(7) One member appointed by the commissioner from a list of three nominees from the Independent Insurance Agents of Louisiana, or its successor.

(8) One member appointed by the governor from a list of three nominees from the National Association of Independent Insurers, or its successor.

(9) One member appointed by the governor from a list of three nominees from the American Insurance Association, or its successor.

(10) One member appointed by the governor from a list of three nominees from the Alliance of American Insurers, or its successor.

(11) One member appointed by the governor from a list of two nominees from the insurer with the largest direct written premium in the state of the subject lines of business.

B. The quorum necessary for transaction of business is hereby established as seven members of the board in attendance.

C. The members of the board shall elect the chairman.

D. The members of the board shall receive no salary, but each member shall be reimbursed for necessary travel and other expenses actually incurred while in attendance at the meetings of the board or on business for the board.

Acts 2003, No. 1133, §1.

§1430.4. Coastal Plan and FAIR Plan; re-created and continued

A. There is hereby re-created and continued the Louisiana Insurance Underwriting Plan (Coastal Plan), which beginning January 1, 2004, shall be available as an insurance program of the Louisiana Citizens Property Insurance Corporation. All assessable insurers shall participate in assessments levied by the Coastal Plan, so long as the Coastal Plan is in existence, as a condition of continuing authority to transact the business of insurance in this state.

B. There is hereby re-created and continued the Louisiana Joint Reinsurance Plan (FAIR Plan), which beginning January 1, 2004, shall be available as an insurance program of the Louisiana Citizens Property Insurance Corporation. All assessable insurers shall participate in assessments levied by the FAIR Plan, so long as the FAIR Plan is in existence, as a condition of continuing authority to transact the business of insurance in this state.

Acts 2003, No. 1133, §1.

§1430.5. Immunity from liability

A. There shall be no liability on the part of and no cause of action of any nature shall arise against the Louisiana Insurance Rating Commission or any of its staff, or against the governing board of the Louisiana Citizens Property Insurance Corporation or anyone acting on behalf of the corporation or the plans, or against any servicing carrier or carriers, or against any assessable insurer, or against any participating insurance producer, or against the Department of Insurance or its representatives, for any action taken by them in the performance of their duties or responsibilities under this Subpart.

B. Such immunity from liability does not apply to:

(1) Any of the persons or entities listed in Subsection A hereof for any willful tort or criminal act.

(2) The corporation, or insurance producers placing business with one of the plans, for breach of any contract or agreement pertaining to insurance coverage.

(3) The corporation with respect to issuance or payment of debt.

(4) Any assessable insurer with respect to any action to enforce such insurer's obligations to the corporation under this Subpart.

Acts 2003, No. 1133, §1.

§1430.6. Powers and duties of Louisiana Citizens Property Insurance Corporation

A. The Louisiana Citizens Property Insurance Corporation shall operate insurance plans which shall function exclusively as residual market mechanisms to provide essential property insurance for residential and commercial property for applicants who are in good faith entitled, but are unable, to procure insurance through the voluntary market. The corporation shall not offer private or commercial automobile or vehicle insurance. The corporation shall operate according to a plan of operation pursuant to R.S. 22:1430.7.

B. The governing board of the corporation shall, pursuant to the provisions of this Subpart and the plan of operation and with respect to essential property insurance on insurable property, have the power:

(1) To cause to be issued policies of insurance to eligible applicants; and

(2) To employ or retain such persons as are necessary to perform the duties of the corporation.

C. The corporation may:

(1) Purchase reinsurance on risks insured by the corporation and the plans.

(2) Borrow funds necessary to effect the purposes of this Subpart. In connection therewith, the corporation may agree to such terms and conditions as it deems necessary and proper and the corporation may assign to the state or any agency or authority thereof, or to any private entity, the right to the receipt of assessments levied by the corporation on behalf of one or more of the plans, to the extent necessary to provide for the payment of bonds issued by the state or such agency or authority, or such private agency, for the purpose of providing for the repayment of such borrowings.

(3) Sue or be sued. The power to sue includes the power and right to intervene as a party before any court in this state in any matter involving the plans or the corporation's powers and duties.

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this Subpart.

D. The corporation shall:

(1) Maintain separate accounts and records for the Coastal Plan and the FAIR Plan for all policies, revenues, assets, liabilities, losses, and expenses.

(2) Retain any profits or excess reserves generated, to be used to offset deficits incurred by the plans. Such retained funds shall be invested pursuant to the limitations set forth in this Title for insurers.

(3) Develop and annually reassess a reasonable and prudent reinsurance program, for the benefit of the policyholders of the plans, to enhance the capability of the corporation to timely and efficiently handle claims from a hurricane or other natural disaster.

(4) Take all actions necessary to facilitate and maintain tax-free status for the income and operations of the corporation and the plans, and to facilitate tax-free status for bonds or other indebtedness issued by or on behalf of the corporation or the plans.

(5) Upon depopulation of the plans, such that less than one thousand policies are written in a plan year, and a determination by the governing board that the declaration and purpose as set forth in R.S. 22:1430 no longer requires operation of the plans, and with approval of the Louisiana Senate Committee on Insurance and the Louisiana House Committee on Insurance and the commissioner of insurance, effectuate a plan of dissolution of the corporation. Upon dissolution, the assets of the corporation shall be applied first to pay all debts, liabilities, and obligations of the corporation, including the establishment of reasonable reserves for any contingent liabilities or obligations, and all remaining assets of the corporation shall become property of the state and be deposited in the general fund. However, no dissolution shall take effect as long as the corporation has bonds or other financial obligations outstanding unless adequate provision has been made for the payment of the bonds or other financial obligations pursuant to the documents authorizing the issuance of the bonds or other financial obligations.

(6) Perform such other acts as are necessary or proper to effectuate the purpose of this Subpart.

Acts 2003, No. 1133, §1.

§1430.7. Plan of operation of Louisiana Citizens Property Insurance Corporation

A.(1) A plan of operation adopted by the governing board of the Louisiana Citizens Property Insurance Corporation shall be filed with and approved by the Louisiana Senate Committee on Insurance and the Louisiana House Committee on Insurance, and filed with the office of property and casualty of the Department of Insurance. The plan of operation shall include the establishment of necessary facilities and operating procedures; management of the corporation; procedures for assessment of assessable insurers and assessable insureds to defray deficits in one or more of the plans; underwriting standards; procedures for the purchase and cession of reinsurance; procedures for determining the amounts of insurance to be provided to specific risks; procedures for the development of requests for proposals, which shall incorporate an open access plan, and shall be prerequisite to any servicing company contract; procedures for processing applicants for insurance; provisions for attaining depopulation of the plans; and such other provisions as may be deemed necessary to carry out the purposes of this Subpart.

(2) The Louisiana Senate Committee on Insurance and the Louisiana House Committee on Insurance and the office of property and casualty may, in their discretion, consult with the governing board of the corporation and may seek any further information deemed necessary.

B.(1) The governing board of the corporation may, subject to the approval of the Louisiana Senate Committee on Insurance and the Louisiana House Committee on Insurance, amend the plan of operation at any time. The Louisiana Senate Committee on Insurance and the Louisiana House Committee on Insurance and the office of property and casualty may review the plan of operation at any time deemed prudent, but not less than once in each calendar year.

(2) Notwithstanding the provisions of Paragraph (1) of this Subsection, the governing board of the corporation shall not have the authority to amend the plan of operation to expand on the declaration and purpose as set forth in R.S. 22:1430, or to expand on the essential property insurance and subject lines of business as defined in R.S. 22:1430.1.

(3) Amendments to the plan of operation shall be submitted to the House and Senate Committees on Insurance. Either committee may conduct a hearing on the amendments within thirty days of submission of the amendments to the respective committee. If no hearing is conducted by either committee within the thirty days, the amendments are deemed to be approved.

C. The Louisiana Senate Committee on Insurance and the Louisiana House Committee on Insurance may, by order, withdraw all or part of a plan of operation if it determines that conditions have changed since approval was granted, or that the public purpose of the corporation and the plans require changes in the plan of operation.

Added by Acts 2003, No. 1133, §1; Acts 2005, No. 217, §1, eff. June 29, 2005.

§1430.8. Functions of assessable insurers participating in the Coastal Plan

A. All assessable insurers shall participate in assessments of the Coastal Plan in the proportion that the net direct premium of such participant written in this state during the preceding calendar year bears to the aggregate net direct premiums written in this state by all assessable insurers during the preceding calendar year as certified to the governing board of the Louisiana Citizens Property Insurance Corporation by the Louisiana Insurance Rating Commission after review of annual statements, other reports and other statistics the Louisiana Insurance Rating Commission shall deem necessary to provide the information herein required and which the Louisiana Insurance Rating Commission is hereby authorized and empowered to obtain from all assessable insurers. Assessable insurers shall not participate in the gains or losses of the Coastal Plan.

B. The governing board of the corporation may adopt, in accordance with the plan of operation approved by the Louisiana Senate Committee on Insurance and the Louisiana House Committee on Insurance, a credit schedule for essential property insurance voluntarily written in the coastal areas, and participation by assessable insurers in the writings in the Coastal Plan may be reduced in accordance with the provisions of such credit schedule. The governing board shall define the term "essential property insurance" for the purposes of this Section.

C. Any insurer who becomes authorized to engage in writing property insurance within Louisiana and who engages in writing property insurance within Louisiana shall become an assessable insurer in the Coastal Plan on January first, immediately following such authorization, and shall cease to be an assessable insurer one year after the end of the first calendar year during which the insurer no longer holds a certificate of authority to transact insurance for subject lines of business in this state.

Acts 2003, No. 1133, §1.

§1430.9. Functions of insurers participating in the FAIR Plan

A. All assessable insurers shall participate in assessments of the FAIR Plan in the proportion that the net direct premium of such participant written in this state during the preceding calendar years bears to the aggregate net direct premiums written in this state by all assessable insurers during the preceding calendar year as certified to the governing board of the corporation after review of annual statements, other reports, and other statistics necessary to provide the information herein required and which the Louisiana Insurance Rating Commission is hereby authorized and empowered to obtain from all assessable insurers. Assessable insurers shall not participate in the gains or losses of the FAIR Plan.

B. The governing board of the corporation may adopt, in accordance with the plan of operation approved by the Louisiana Senate Committee on Insurance and the Louisiana House Committee on Insurance, a credit schedule for essential property insurance voluntarily written, and participation by assessable insurers in the writings in the FAIR Plan may be reduced in accordance with the provisions of such credit schedule. The governing board shall define the term "essential property insurance" for the purposes of this Section.

C. Any insurer who becomes authorized to engage in writing property insurance within Louisiana and who engages in writing property insurance within Louisiana shall become an assessable insurer in the FAIR Plan on January first immediately following such authorization, and shall cease to be an assessable insurer one year after the end of the first calendar year during which the insurer no longer holds a certificate of authority to transact insurance for subject lines of business in this state.

Acts 2003, No. 1133, §1.

§1430.10. Assessable insureds

A. All persons who procure one or more subject lines of business from an assessable insurer are subject to emergency assessment by the corporation, and are referred to collectively as "assessable insureds".

B. When an emergency assessment is levied by the corporation, the assessment percentage applicable to each assessable insured is the ratio of the total amount being assessed by the corporation to the aggregate statewide direct written premium for the subject lines of business for the prior year.

C. Emergency assessments levied by the corporation on assessable insureds shall be collected by all assessable insurers at the time an assessable insured procures a policy of insurance for a subject line of business. Assessable insurers shall remit the collected emergency assessments to the corporation in accordance with guidelines included in the corporation's plan of operation. Emergency assessments shall not be considered premium.

D. Assessable insurers shall be permitted to recoup all regular assessments from their voluntary policyholders by applying a surcharge to all policies issued for subject lines of business. The surcharge shall be a uniform percentage of premium, but shall not be considered premium. Assessable insurers shall cease to collect the recoupment surcharge once the full amount of the regular assessment has been collected. If an assessable insurer recoups more than its fair share of a regular assessment, all funds collected in excess of the insurer's share of the regular assessment shall be remitted to the corporation for use in defraying future deficits. Assessable insurers shall notify the department at least thirty days in advance of the commencement of such a surcharge.

Acts 2003, No. 1133, §1.

§1430.11. Eligibility; application

A. Any person having an insurable interest in insurable property is entitled to apply to the corporation, directly or through a representative, for such coverage through the Coastal Plan or the FAIR Plan, and for an inspection of the property. Every such application shall be submitted on forms prescribed by the governing board of the corporation and on file with the office of property and casualty of the Department of Insurance.

B. The term "insurable interest" as used in this Section shall be deemed to include any lawful and substantial economic interest in the safety and preservation of property from loss, destruction, or pecuniary damage.

C. If the corporation determines that the property is insurable, the corporation, upon receipt of the premium or such portion thereof as is prescribed for either the Coastal Plan or the FAIR Plan, shall cause to be issued the appropriate policy of essential property insurance for a term not exceeding one year. Any policy issued pursuant to the provisions of this Section shall be renewed annually, upon payment of premium due, so long as the property meets the definition of "insurable property".

D. If the corporation for any reason denies an application and refuses to cause to be issued an insurance policy on insurable property to any applicant, or takes no action on an application within the time prescribed in the plan of operation, such applicant may appeal to the Louisiana Insurance Rating Commission and the said commission or a member of the commission's staff designated by it, after reviewing the facts, may direct the corporation to issue, or cause to be issued, an appropriate insurance policy to the applicant. In carrying out its duties pursuant to this Section, the Louisiana Insurance Rating Commission may request and the corporation shall provide any information which the Louisiana Insurance Rating Commission deems necessary to a determination concerning the reason for the denial or delay of the application.

Acts 2003, No. 1133, §1.

§1430.12. Rates, rating plans, and rate rules applicable

A.(1) As residual markets, the plans made available by the Louisiana Citizens Property Insurance Corporation are not intended to offer rates competitive with the voluntary market. Rates for policies issued under the Coastal Plan and the FAIR Plan shall be set by the governing board of the Louisiana Citizens Property Insurance Corporation, adjusted annually, shall be actuarially justified, and shall exceed by at least ten percent the rates charged among the ten insurers with the greatest total direct written premium in each parish for that line of business in the preceding year; except that, with respect to mobile home coverages, the average rates of the plans shall exceed by at least ten percent the rates charged among the five insurers with the greatest total written premium for mobile homeowners' policies in each parish in the preceding year. Such rates shall include an appropriate catastrophe loading factor, and may include rules for classification of risks insured hereunder and rate modifications hereof. The rates charged in a particular parish shall exceed by at least ten percent the rates of any insurer that has a minimum of three percent of the total premium for the parish.

(2) The method used to determine the rates charged among the ten insurers with the greatest total direct written premium in each parish and used to determine the rates charged among the five insurers with the greatest total written premium for mobile homeowners' policies in each parish shall be set forth in the annual rate review provided by the governing board and shall be documented in the rate filing as required in Subsection C of this Section.

(3) Prior to determining any such rates the governing board shall adopt such formulas as may be necessary for determining the rates.

B. In addition to the rates otherwise determined pursuant to this Section, including the premium tax provided for in R.S. 22:1065, the corporation shall impose and collect an additional amount equal to the premium tax provided for in R.S. 22:1065 to augment the financial resources of the corporation. Said additional amount equal to the premium tax shall be designated as a charge accruing to the state of Louisiana, but shall be retained by the corporation as a state contribution to the corporation for the public purpose as set forth in R.S. 22:1430.

C. The corporation shall make a rate filing at least once a year for the plans, and nothing in this Section shall require or permit the corporation to adopt a rate that is inadequate under R.S. 22:1401 et seq. Subject to the provisions of Subsections A and B of this Section, the rates shall be approved by the Louisiana Insurance Rating Commission prior to use.

Added by Acts 2003, No. 1133, §1; Acts 2005, No. 217, §1, eff. June 29, 2005.

§1430.13. Reports of inspection

All reports of inspection performed by the corporation shall be made available to the assessable insurers participating in the Coastal Plan and the FAIR Plan, and the Louisiana Insurance Rating Commission. An applicant or his representative shall be entitled to a copy of any inspection report on property in which the applicant has an insurable interest.

Acts 2003, No. 1133, §1.

§1430.14. Annual and quarterly reports

A. The corporation shall file in the office of the Louisiana Insurance Rating Commission, and in the office of property and casualty of the Department of Insurance, annual and quarterly statements as required for authorized insurers pursuant to R.S. 22:1451; and annual audited statements which shall summarize the transactions, conditions, operations, and affairs of the Coastal Plan and FAIR plans, as a program of the Louisiana Citizens Property Insurance Corporation during the preceding fiscal year ending December thirty-first. Nothing in this Section shall be construed to affect the reporting requirements or fiscal years of the Coastal Plan and the FAIR Plan with respect to policies issued by the Louisiana Insurance Underwriting Plan and the Louisiana Joint Reinsurance Plan on and prior to December 31, 2003.

B. The corporation shall report quarterly to the Louisiana Insurance Rating Commission and the office of property and casualty on the types, premium, exposure, and distribution by parish of its policies in force, and submit such other reports as may be required by the Louisiana Insurance Rating Commission to fulfill its responsibilities.

Added by Acts 2003, No. 1133, §1; Acts 2004, No. 46, §1, eff. May 21. 2004.

§1430.15. Examination of corporation

The commissioner of insurance shall make examinations of the Louisiana Citizens Property Insurance Corporation and the plans in the manner as provided by R.S. 22:1301 for examination of insurers. The expense of such examinations shall be borne and paid by the corporation. The corporation and the plans shall be subject to examination by the legislative auditor.

Acts 2003, No. 1133, §1.

§1430.16. Plan deficits; financing

A. In the event that the governing board of the Louisiana Citizens Property Insurance Corporation determines that a deficit exists in either the Coastal Plan or the FAIR Plan, the corporation may levy regular and emergency assessments for each affected plan in order to remedy such deficit. An assessment shall not be levied on assessable insurers and assessable insureds unless and until all profits and excess reserves over and above reasonably anticipated recurring operating costs have been exhausted and the governing board has projected a deficit in the plan for which an assessment is to be levied.

B. When the deficit incurred in a particular calendar year is not greater than ten percent of the aggregate statewide direct written premium for the subject lines of business for the prior calendar year, the entire deficit shall be recovered through regular assessments of assessable insurers.

C. When the deficit incurred in a particular calendar year exceeds ten percent of the aggregate statewide direct written premium for the subject lines of business for the prior calendar year, the corporation shall levy regular assessments on assessable insurers in an amount equal to the greater of ten percent of the deficit or ten percent of the aggregate statewide direct written premium for the subject lines of business for the prior calendar year. Any remaining deficit shall be recovered through emergency assessments.

D. Each assessable insurer's share of any regular assessment under Subsection B or C of this Section shall be calculated in accordance with R.S. 22:1430.8 and 1430.9. Assessments levied by the corporation on assessable insurers under Subsection B or C of this Section shall be paid as required by the corporation's plan of operation.

E. Upon a determination by the governing board that a deficit in a plan exceeds the amount that will be recovered through regular assessments under Subsection B or C of this Section, the governing board shall levy, after verification by the department, emergency assessments, for as many years as necessary to cover the deficits, to be collected by assessable insurers and the corporation and collected from all assessable insureds upon issuance or renewal of policies for subject lines of business, excluding National Flood Insurance policies. The amount of the emergency assessment collected in a particular year shall be a uniform percentage of that year's direct written premium for subject lines of business and all plan accounts of the corporation, excluding National Flood Insurance Program policy premiums, as annually determined by the governing board and verified by the department. The department shall verify the arithmetic calculations involved in the governing board's determination within thirty days after receipt of the information on which the determination was based. Notwithstanding any other provision of law, the corporation and each assessable insurer that writes subject lines of business shall collect emergency assessments from its policyholders without such obligation being affected by any credit, limitation, exemption, or deferment. Emergency assessments levied by the corporation on assessable insureds shall be collected by assessable insurers in accordance with guidelines included in the corporation's plan of operation. The emergency assessments so collected shall be held by the corporation solely in the applicable plan account. The aggregate amount of emergency assessments levied for a plan under this Subsection in any calendar year may not exceed the greater of ten percent of the amount needed to cover the original deficit, plus interest, fees, commissions, required reserves, and other costs associated with financing of the original deficit, or ten percent of the aggregate statewide direct written premium for subject lines of business and for all plan accounts of the corporation for the prior year, plus interest, fees, commissions, required reserves, and other costs associated with financing the original deficit. Emergency assessments shall be shown separately on the declarations page of policies issued for subject lines of business, and shall not be considered premium, nor subject to any premium taxes or other charges.

F. Policies issued by the corporation shall be subject to emergency assessments, as specified in Subsection E hereof. Furthermore, when a regular assessment is levied, all policies shall be subject to a market equalization charge. The market equalization charge shall be a uniform percentage of premium. The market equalization charge percentage shall be the ratio of the total regular assessment levied by the corporation to the aggregate statewide direct written premium for subject lines of business for the prior year. The market equalization charge shall not be considered premium. Assessable insurers shall notify the Louisiana Insurance Rating Commission at least thirty days in advance of the commencement of such a charge.

G. The corporation may pledge the proceeds of assessments, insurance and reinsurance recoverables, surcharges, and other funds available to the corporation as the source of revenue for and to secure bonds or other indebtedness, or lines of credit or other financing mechanisms issued or created under this Subsection, or to retire any other debt incurred as a result of deficits or events giving rise to deficits, or in any other way that the governing board determines will efficiently recover such deficits. The purpose of the lines of credit or other financing mechanisms is to provide additional resources to assist the corporation in covering claims and expenses attributable to a catastrophe. As used in this Subsection, the term "assessments" includes regular assessments under Subsection B or C of this Section, and emergency assessments under Subsection E of this Section. Emergency assessments collected under Subsection E of this Section are not part of an insurer's rates, are not premium, and are not subject to premium tax, fees, or commissions. However, failure to pay the emergency assessment shall be treated as failure to pay premium. The emergency assessments under Subsection E of this Section shall continue as long as any bonds issued or other indebtedness incurred with respect to a deficit for which the assessment was imposed remain outstanding, unless adequate provision has been made for the payment of such bonds or other indebtedness pursuant to the documents governing such bonds or other indebtedness.

H. The office of property and casualty shall determine annually the aggregate statewide written premium in subject lines of business and shall report that information to the corporation in a form and at a time the corporation specifies to ensure that the corporation can meet the requirements of this Section and the corporation's financing obligations.

I. All bonds, other indebtedness, lines of credit, or other financing mechanisms under this Section shall be approved by the Louisiana State Bond Commission.

J. Under no circumstances shall it be construed that the full faith and credit of the state of Louisiana be used to secure the bonds or indebtedness issued under this Section. Any offering documents associated with any debts under this Section shall clearly state it is not secured by the full faith and credit of the state.

Acts 2003, No. 1133, §1.

§1430.17. Louisiana Citizens Property Insurance Corporation not taxable

The corporation shall be considered a political instrumentality of the state, and shall be exempt from any corporate income tax. However, the corporation is not and shall not be deemed a department, unit, or agency of the state. All debts, claims, obligations, and liabilities of the corporation, whenever and however incurred, shall be the debts, claims, obligations, and liabilities of the corporation only, and not of the state, its agencies, officers, or employees. Corporation funds shall not be considered part of the general fund of the state, and the state shall not appropriate corporation funds. The state's contribution to the corporation is limited to those funds collected by the corporation pursuant to the authority granted under R.S. 22:1430.12(B) of this Subpart, and the state shall not budget for or provide general fund appropriations to the corporation. The premiums, assessments, investment income, and other revenue of the corporation are funds received for providing property insurance coverage as required by this Section, paying claims for Louisiana citizens insured by the corporation's plans, securing and repaying debt obligations issued by the corporation, and conducting all other activities of the corporation, and shall not be considered taxes, fees, licenses, or charges for services imposed by the legislature on individuals, businesses, or agencies outside state government. It is the intent of the legislature that the tax exemptions provided in this Section will augment the financial resources of the corporation to better enable fulfillment of the public purpose. Any bonds issued by or on behalf of the corporation and the plans, their transfer, and the income therefrom, including any profit made on the sale thereof, shall at all times be free from taxation of every kind by the state and any political subdivision or local unit or other instrumentality thereof.

Acts 2003, No. 1133, §1.

§1430.18. Operation of the Coastal and FAIR Plans; requirements

The governing board of the corporation shall provide property insurance pursuant to this Part which shall include any property easily accessible by road for emergency vehicles.

Added by Acts 2004, No. 665, §1.

§1431. REPEALED BY ACTS 2003, No. 1133, §2.
§1432. REPEALED BY ACTS 2003, No. 1133, §2.
§1433. REPEALED BY ACTS 2003, No. 1133, §2.
§1434. REPEALED BY ACTS 2003, No. 1133, §2.
§1435. REPEALED BY ACTS 2003, No. 1133, §2.
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§1437. REPEALED BY ACTS 2003, No. 1133, §2.
§1438. REPEALED BY ACTS 2003, No. 1133, §2.
§1439. REPEALED BY ACTS 2003, No. 1133, §2.
§1440. REPEALED BY ACTS 2003, No. 1133, §2.
§1441. REPEALED BY ACTS 2003, No. 1133, §2.

§1441.1. Louisiana Insurance Underwriting Plan (Coastal Plan); definitions

As used in R.S. 22:1441.1 through 1441.13, unless the context otherwise requires:

(1) "Coastal area" means all of that area of the state designated in the "plan" approved by the Louisiana Insurance Rating Commission.

(2) "Essential property insurance" means any of the following coverages against direct loss to property as defined by the plan approved by the Louisiana Insurance Rating Commission:

(a) Fire, with or without extended coverage and vandalism and malicious mischief.

(b) Windstorm and hail without fire, but only with respect to dwellings and commercial properties on a monoline basis.

(c) Homeowners.

(3) "Governing committee" means that group which is referred to in R.S. 22:1441.4 and, where appropriate, any designee of the governing committee.

(4) "Insurable property" means immovable property at fixed locations in coastal areas of the state as that term is hereinafter defined or the corporeal movable property located therein (but shall not include insurance on motor vehicles) which property is determined by the governing committee of the plan, after inspection and pursuant to the criteria specified in the plan, to be in an insurable condition against the perils of fire as determined by normal underwriting standards; however, any structure built in substantial accordance with the Standard Building Code, including the design-wind requirements, which is not otherwise rendered uninsurable by reason of use, occupancy, or state of repair, shall be an insurable risk within the meaning of R.S. 22:1441.1 through 1441.14. Provided further, that any structure commenced on or after July 29, 1970, not built in substantial compliance with the Standard Building Code, including the design-wind requirements therein, shall not be an insurable risk under the terms of R.S. 22:1441.1 through 1441.14. The owner or applicant shall furnish with the application proof in the form of a certificate from a local building inspector, contractor, engineer, or architect that the structure is built in substantial accordance with the Standard Building Code.

(5) "Net direct premiums" means gross direct premiums, excluding reinsurance assumed and ceded, written on property in this state for fire and extended coverage insurance, including components of homeowners' policies and commercial multiple peril package policies, less return premiums upon canceled contracts, dividends paid or credited to policyholders, or the unused or unabsorbed portion of premium deposits. In no event shall premiums on industrial fire insurance policies be considered "net direct premiums".

(6) "Plan" means the document setting the rules of operation approved or promulgated by the Louisiana Insurance Rating Commission relative to the Louisiana Insurance Underwriting Plan.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.2. Louisiana Insurance Underwriting Plan re-created and continued

A. There is hereby re-created and continued the Louisiana Insurance Underwriting Plan. All insurers authorized to write and engage in writing, within this state on a direct basis, property insurance shall participate in the plan.

B. Every such insurer shall participate in the plan so long as the plan is in existence as a condition of its authority to continue to transact the business of insurance in this state.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.3. Powers and duties of the governing committee

The governing committee, or its designee, shall, pursuant to the provisions of this Part and the plan, and with respect to essential property insurance on insurable property, have the power on behalf of the participants:

(1) To cause to be issued policies of insurance having inception dates of and prior to December 31, 2003, to applicants.

(2) To assume reinsurance from the participants.

(3) To cede reinsurance to the participants and to purchase reinsurance in behalf of the participants.

(4) To service or cause to be serviced all policies issued having inception dates on or prior to December 31, 2003, and after all claims arising under said policies have been resolved and the business of Louisiana Insurance Underwriting Plan (Coastal Plan) with respect to such policies has been concluded, to notify the commissioner of insurance, and thereafter dissolve as a committee.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.4. Board of directors of the plan

The governing committee of the plan shall be a board of directors which shall consist of seven representatives of participants in the plan.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.5. Functions of the plan

A. All participants in the plan shall participate in its writings, expenses, profits, and losses in the proportion that the net direct premium of such participant written in this state during the preceding calendar year bears to the aggregate net direct premiums written in this state by all participants in the plan during the preceding calendar year as certified to the governing committee of the plan by the Louisiana Insurance Rating Commission after review of annual statements, other reports and other statistics the Louisiana Insurance Rating Commission shall deem necessary to provide the information herein required and which the Louisiana Insurance Rating Commission is hereby authorized and empowered to obtain from any participant in the plan.

B. A participant shall, in accordance with the plan approved by the Louisiana Insurance Rating Commission, be entitled to receive credit for essential property insurance voluntarily written in the coastal areas and its participation in the writings in the plan shall be reduced in accordance with the provisions of the plan.

C. Any insurer who becomes authorized to engage in writing property insurance within Louisiana and who engages in writing property insurance within Louis iana shall become a participant in the plan on January first, immediately following such authorization, and the determination of such insurer's participation in the plan shall be made as of the date of such participation in the same manner as for all other participants in the plan.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.6. Plan; review and approval

A.(1) The plan shall set forth the number, qualifications, terms of office, and manner of election of the members of the governing committee and a participant shall, in accordance with the plan approved by the Louisiana Insurance Rating Commission, be entitled to receive credit annually for essential property insurance voluntarily written in the coastal areas and shall provide for the efficient, economical, fair, and nondiscriminatory administration of the plan and for the prompt and efficient provision of essential property insurance in the coastal areas of the state so as to promote orderly community development in those areas and to provide means for the adequate maintenance and improvement of the property in such areas.

(2) The plan also may provide for:

(a) The establishment of necessary facilities.

(b) Management.

(c) The assessment of participants to defray losses and expenses.

(d) Underwriting standards.

(e) Procedures for the acceptance and cession of reinsurance by the governing committee, or its designee, on behalf of plan participants.

(f) Procedures for determining the amounts of insurance to be provided to specific risks.

(g) Time limits and procedures for processing applications for insurance and for such other provisions as may be deemed necessary by the Louisiana Insurance Rating Commission to carry out the purposes of this Part.

B. The governing committee of the plan may, subject to the approval of the Louisiana Insurance Rating Commission, amend the plan at any time. The Louisiana Insurance Rating Commission may review the plan at any time it deems expedient or prudent, but not less than once in each calendar year. After review of the plan the Louisiana Insurance Rating Commission may amend it after consultation with the governing committee, or its designee, of the plan, and upon certification to the governing committee of the plan of such amendment.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.7. Eligibility; application

A.(1) Any person having an insurable interest in insurable property is entitled to apply to the governing committee of the plan, directly or through a representative, for such coverage and for an inspection of the property. Every such application shall be submitted on forms prescribed by the governing committee of the plan and approved by the Louisiana Insurance Rating Commission, which application shall contain a statement as to whether or not there are any unpaid premiums due from the applicant for fire insurance on the property.

(2) The term "insurable interest" as used in this Subsection shall be deemed to include any lawful and substantial economic interest in the safety or preservation of property from loss, destruction, or pecuniary damage.

B. If the governing committee of the plan determines that the property is insurable and that there is no unpaid premium due from the applicant for prior insurance on the property, the governing committee of the plan upon receipt of the premium, or such portion thereof as is prescribed in the plan, shall cause to be issued a policy of essential property insurance for a term of one year. Any policy issued pursuant to the provisions of this Section shall be renewed annually, upon payment of premium due, so long as the property meets the definition of "insurable property" as set forth in R.S. 22:1441.1(4).

C. If the governing committee of the plan, for any reason, denies an application and refuses to cause to be issued an insurance policy on insurable property to any applicant or takes no action on an application within the time prescribed in the plan, such applicant may appeal to the Louisiana Insurance Rating Commission and said commission or a member of the commission's staff designated by it, after reviewing the facts, may direct the governing committee of the plan to issue or cause to be issued an insurance policy to the applicant. In carrying out its duties pursuant to this Section, the Louisiana Insurance Rating Commission may request, and the governing committee of the plan shall provide, any information the Louisiana Insurance Rating Commission deems necessary to a determination concerning the reasons for the denial or delay of the application.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.8. Participants shall cede insurance to the plan

Any participant in the plan shall cede to the plan one hundred percent of the essential property insurance written pursuant to and on the terms and conditions set forth in the plan.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.9. Rates, rating plans, and rate rules applicable

The rates, rating plans, and rating rules applicable to the insurance written pursuant to the plan shall be those approved by the Louisiana Insurance Rating Commission; however, such rates may include rules for classification of risks insured hereunder and rate modifications thereof.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.10. Appeal to the Louisiana Insurance Rating Commission; appeal to the court from the Louisiana Insurance Rating Commission

Any person insured pursuant to R.S. 22:1441.1 through 1441.13 or his representative, or any affected insurer, who may be aggrieved by an act, ruling, or decision of the governing committee of the plan may, within thirty days after such ruling, appeal to the Louisiana Insurance Rating Commission. Any hearings held by the Louisiana Insurance Rating Commission pursuant to such an appeal shall be in accordance with the procedure set forth in the insurance laws of Louisiana. Provided, however, the Louisiana Insurance Rating Commission is authorized to appoint a member of its staff for the purpose of hearing such appeals and a ruling based upon such hearing shall have the same effect as if heard by the Louisiana Insurance Rating Commission. All persons or insureds aggrieved by any order or decision of the Louisiana Insurance Rating Commission may appeal as is provided by the provisions of the insurance laws of the state of Louisiana.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.11. Reports of inspection

All reports of inspection performed by or on behalf of the governing committee of the plan shall be made available to the participants in the plan and the Louisiana Insurance Rating Commission. An applicant or his representative shall be entitled to a copy of any inspection report on property in which the applicant has an insurable interest.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.12. Immunity from liability

There shall be no liability on the part of and no cause of action of any nature shall arise against the Louisiana Insurance Rating Commission or any of its staff, or against the governing committee of the plan or anyone acting on its behalf, or against any servicing carrier or carriers of the plan, or against any participating insurer, for any inspections made hereunder or any statements made in good faith by them in any reports or communications concerning risks submitted to the governing committee of the plan or at any administrative hearings conducted in connection therewith under the provisions of this Code.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.13. Annual report

The governing committee of the plan or its designee shall file in the office of the Louisiana Insurance Rating Commission on or before September first of each year a statement which shall summarize the transactions, conditions, operations, and affairs of the plan during the preceding fiscal year ending June thirtieth. Such statement shall contain such matters and information as are prescribed by the Louisiana Insurance Rating Commission and shall be in such form as is required by it. The Louisiana Insurance Rating Commission may at any time require the governing committee of the plan to furnish to it any additional information with respect to its transactions or any other matter which the Louisiana Insurance Rating Commission deems to be material to assist it in evaluating the operation and experience of the plan.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.14. Examination of plan

The commissioner of insurance may from time to time examine the plan when he deems it to be prudent and in undertaking such examination he may hold a public hearing. The expense of such examination shall be borne and paid by the plan participants who shall share the expenses ratably in accordance with their respective participation for the year under examination.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.15. Louisiana Joint Reinsurance Plan (FAIR Plan); definitions

As used in R.S. 22:1441.15 through 1441.26, unless the context otherwise requires:

(1) "Designated area" means all of that area of the state designated in the plan on file with the Louisiana Insurance Rating Commission and designated as FAIR (Fair Access to Insurance Requirements) Plan area.

(2) "Essential property insurance" means any of the following coverages against direct loss to property as defined by the plan approved by the Louisiana Insurance Rating Commission:

(a) Fire, with or without extended coverage and vandalism and malicious mischief.

(b) Windstorm and hail without fire, but only with respect to dwellings and commercial properties on a monoline basis.

(c) Homeowners.

(3) "Governing committee" means that group which is referred to in R.S. 22:1441.17 and, where appropriate, any designee of the governing committee.

(4) "Insurable property" means real and tangible personal property at a fixed location in a designated area of Louisiana when such property is in an insurable condition and basic property insurance is not obtainable in the normal market.

(5) "Net direct premiums" means gross direct premiums, excluding reinsurance assumed and ceded, written on property in this state for fire and extended coverage and, if provided in the plan, homeowners insurance, including premium components of all multiperil policies and homeowners' policies, less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits. In no event shall premiums on industrial fire insurance policies be considered as net direct premiums.

(6) "Plan" means the document setting the rules of operation approved or promulgated by the Louisiana Insurance Rating Commission relative to the Louisiana Joint Reinsurance Plan.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.16. Louisiana Joint Reinsurance Plan; immunity from liability; Louisiana Insurance Rating Commission

A. The Louisiana Joint Reinsurance Plan is hereby continued and reestablished and all insurers authorized to write and engage in writing property insurance within Louisiana on a direct basis are required to be participants in the plan.

B. The Louisiana Insurance Rating Commission is hereby authorized to issue rules and regulations for the purpose of carrying out the provisions of R.S. 22:1441.15 through 1441.26.

C. There shall be no liability on the part of and no cause of action of any nature shall arise against the Louisiana Insurance Rating Commission or any of its staff, or against the governing committee of the Louisiana Joint Reinsurance Plan or anyone acting on its behalf, or against any servicing carrier or carriers, or against any participating insurer, for any inspections made hereunder or any statements made in good faith by them in any reports or communications concerning risks submitted to the governing committee of the plan or at any administrative hearings conducted in connection therewith under the provisions of R.S. 22:1441.15 through 1441.26.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.17. Powers and duties of the governing committee

The governing committee shall, pursuant to the provisions of this Part and the plan, and with respect to essential property insurance on insurable property, have the power on behalf of the participants:

(1) To cause to be issued policies of insurance having inception dates of and prior to December 31, 2003, to applicants.

(2) To assume reinsurance from the participants.

(3) To cede reinsurance to the participants and to purchase reinsurance on behalf of the participants.

(4) To service or cause to be serviced all policies issued having inception dates on or prior to December 31, 2003, and after all claims arising under said policies have been resolved and the business of the Louisiana Joint Reinsurance Plan (Fair Plan) with respect to such policies has been concluded, to notify the commissioner of insurance, and thereafter dissolve as a committee.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.18. Board of directors of plan

The governing committee of the plan shall be a board of directors which shall consist of seven representatives of participants in the plan.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.19. Functions of participants in the plan

A. All participants in the plan shall participate in the writings, expenses, profits, and losses in the proportion that the net direct premium of such participant written in this state during the preceding calendar years bears to the aggregate net direct premiums written in this state by all participants in the plan in the preceding calendar year as certified to the governing committee of the plan after review of annual statements, other reports, and other statistics necessary to provide the information herein required and which the Louisiana Insurance Rating Commission is hereby authorized and empowered to obtain from any participant in the plan.

B. However, each participant shall be entitled to receive credit for essential property insurance voluntarily written in designated areas. The governing committee of the plan shall define the terms "essential property insurance" and "designated areas" for the purposes of this Section.

C. Any insurer who becomes authorized to engage in writing property insurance within Louisiana and who engages in writing property insurance within Louisiana shall become a participant in the plan on January first immediately following such authorization and writing, and the determination of such insurer's participation in the plan shall be made as of the date of such participation in the same manner as for all other participants in the plan.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.20. Plan

A.(1) The plan as filed and approved by the Louisiana Insurance Rating Commission shall continue. The plan shall set forth the number, qualifications, terms of office, and manner of election of the members of the governing committee. The plan may include the assessment procedures of all participants for expenses necessary to the operation; the establishment of necessary facilities; management of the plan; plan for assessment of participants to defray losses and expenses; underwriting standards; procedures for the acceptance and cession of reinsurance on behalf of the participants; procedures for determining the amounts of insurance to be provided to specific risks; procedures for processing applicants for insurance; and such other provisions as may be deemed necessary to carry out the purposes of R.S. 22:1441.15 through 1441.26.

(2) The plan shall be filed with the Louisiana Insurance Rating Commission and the Louisiana Insurance Rating Commission may, in its discretion, consult with the governing committee of the plan and may seek any further information which it deems necessary for a decision.

B. The governing committee of the plan may, subject to the approval of the Louisiana Insurance Rating Commission, amend the plan at any time. The Louisiana Insurance Rating Commission may review the plan at any time it deems prudent, but not less than once in each calendar year. After review of the plan, the Louisiana Insurance Rating Commission may amend it after consultation with the governing committee of the plan, and upon certification to the governing committee of such amendment.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.21. Eligibility; application

A. Any person having an insurable interest in insurable property is entitled to apply to the governing committee of the plan, directly or through a representative, for such coverage and for an inspection of the property. Every such application shall be submitted on forms prescribed by the governing committee of the plan and on file with the Louisiana Insurance Rating Commission.

B. The term "insurable interest" as used in this Section shall be deemed to include any lawful and substantial economic interest in the safety and preservation of property from loss, destruction, or pecuniary damage.

C. If the governing committee of the plan determines that the property is insurable, the governing committee of the plan, upon receipt of the premium or such portion thereof as is prescribed in the plan, shall cause to be issued a policy of essential property insurance for a term not exceeding one year. Any policy issued pursuant to the provisions of this Section shall be renewed annually, upon payment of premium due, so long as the property meets the definition of "insurable property".

D. If the governing committee of the plan for any reason denies an application and refuses to cause to be issued an insurance policy on insurable property to any applicant, or takes no action on an application within the time prescribed in the plan, such applicant may appeal to the Louisiana Insurance Rating Commission and the said commission or a member of the commission's staff designated by it, after reviewing the facts, may direct the governing committee of the plan to issue, or cause to be issued, an insurance policy to the applicant. In carrying out its duties pursuant to this Section, the Louisiana Insurance Rating Commission may request and the governing committee of the plan shall provide any information which the Louisiana Insurance Rating Commission deems necessary to a determination concerning the reason for the denial or delay of the application.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.22. Plan participants shall cede insurance

All participants in the plan shall cede one hundred percent of the essential property insurance written pursuant to and on terms and conditions set forth in the plan.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.23. Rates, rating plans, and rate rules applicable

Rates shall be in accordance with the rating plans approved by the Louisiana Insurance Rating Commission for use by the Property Insurance Association of Louisiana; however, such rates may include rules for classification of risks insured hereunder and rate modifications hereof.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.24. Reports of inspection

All reports of inspection performed by the governing committee of the plan shall be made available to the participants in the plan and the Louisiana Insurance Rating Commission. An applicant or his representative shall be entitled to a copy of any inspection report on property in which the applicant has an insurable interest.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.25. Annual report

The governing committee of the plan shall file in the office of the Louisiana Insurance Rating Commission each year a statement which shall summarize the transactions, conditions, operations, and affairs of the plan during the preceding fiscal year ending September thirtieth.

R.S. 22§1448. REPEALED BY ACTS 1987, No. 313, §2.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1441.26. Examination of plan

The commissioner of insurance may from time to time make an examination into the affairs of the plan when he deems it to be prudent and, in undertaking such examination, he may hold a public hearing. The expense of such examination shall be borne and paid by plan participants who shall share the expense ratably in accordance with their respective participation for the year under examination.

Added by Acts 2004, No. 761, §1, eff. July 6, 2004.

§1442. REPEALED BY ACTS 2003, No. 1133, §2.

§1443. REPEALED BY ACTS 2003, No. 1133, §2.

§1444. REPEALED BY ACTS 2003, No. 1133, §2.

§1445. REPEALED BY ACTS 2003, No. 1133, §2.

SUBPART C. RULES, ENFORCEMENT, AND MISCELLANEOUS PROVISIONS

§1446. Rules and regulations

The Louisiana Insurance Rating Commission shall have authority to make reasonable rules and regulations, not inconsistent with law, to enforce, carry out and make effective the provisions of this Part.

Added by Acts 1970, No. 35, §1, emerg. eff. June 18, 1970, at 5 p.m.; Acts 1992, No. 379, §1; Acts 2003, No. 1133, §3.

§1447. Failure to comply with written orders or directives; penalties

If any insurance company or rating organization fails to comply with a written directive or order issued by the Louisiana Insurance Rating Commission pursuant to this Part within thirty days of the issuance thereof, the Louisiana Insurance Rating Commission may levy and receive a fine of up to twenty-five thousand dollars. The penalty shall not be imposed until such time that the Louisiana Insurance Rating Commission makes a finding that the penalty is warranted in a proper hearing, held in the manner provided in Part XXIX of Chapter 1 of this Title.

Added by Acts 1978, No. 524, §1; Acts 1987, No. 313, §1; Acts 1990, No. 647, §1.

§1448. REPEALED BY ACTS 1987, No. 313, §2.

PART XXX-A. JOINT LEGISLATIVE COMMITTEE ON INSURANCE

§1450. [Blank]

§1450.1. Legislative purpose

A. The legislature recognizes that the subject and availability of insurance is one of great importance and of great interest to the people and business of this state, and revelations indicate that the state's insurance laws and the regulatory scheme and processes applicable thereto are vague and inadequate to protect and meet the needs and interest of the public, business and the industry.

B. It is therefore determined that there is an overriding public need to carefully study and recommend changes to the insurance code and to carefully consider and deliberate on the entire subject matter so as to restore confidence of the public in the insurance industry, its products, and the regulatory agencies and departments of the state and their operation, independence and reliability.

C. There is also a need to hear the testimony, comments and problems of the general public who desire to buy insurance and of those unable to obtain coverage.

D. The legislature feels strongly that the insurance needs and insurance administration of state and local governments, including all agencies, instrumentalities and their employees should be examined, and ways and means suggested to streamline adequate and uniform coverage and adequate access to coverage, its delivery, with alternatives, ease of claims, expeditious processing, payment and administration for all governmental units and employees with the notion of eliminating duplication and saving money for the public.

Acts 1990, No. 995, §1, eff. July 26, 1990.

§1450.2. Joint Legislative Committee on Insurance; creation; composition

A. The Joint Legislative Committee on Insurance is hereby created to undertake a comprehensive study and revision of the insurance laws of the state.

B. The committee shall be composed of ten members. Three members of the Senate Committee on Insurance shall be appointed by the chairman of that committee and five members of the House Committee on Insurance shall be appointed by the chairman of that committee. The chairman of the Senate Committee on Insurance and the chairman of the House Committee on Insurance shall be ex officio voting members and shall serve as cochairmen.

C. A quorum of the committee shall consist of a majority of the total membership.

D. No action on any provisions recommended by the committee to be included in the proposed draft code shall be taken by the joint committee except by a favorable vote of a majority of the members from each house serving on the committee, each house voting separately.

E. The committee shall cease to function under the provisions of this Part on September 1, 1992.

Acts 1990, No. 995, §1, eff. July 26, 1990; Acts 1992, No. 377, §1, eff. June 17, 1992.

§1450.3. Duties

The committee shall recommend to the legislature such changes in the insurance laws as may be needed in order to:

(1) Make a thorough and complete study of the industry and state, federal and local regulations.

(2) Simplify the meaning, verbiage, regulation, procedures, and administration of the insurance laws of this state and to protect the consuming public.

(3) Improve domestic insurance business and to encourage foreign insurers to domicile in Louisiana.

(4) Provide for uniform handling of all legal matters relative to the Department of Insurance and the Insurance Rating Commission, including procedures, proceedings, hearings, liquidation, conservation, rehabilitation, trials, appeals, and other legal or administrative proceedings as well as legal policy.

(5) Make a comprehensive study of the type of companies licensed or otherwise doing business in Louisiana and various lines of business or risk takers, self-insurers, and their products compulsory insurance, insurance needs of state and local governments and all agencies or instrumentalities thereof, all aspects of the financial solvency, incorporation procedures and requirements, insurance filings and ratings, including the office of insurance commissioner, the Department of Insurance, and the Insurance Rating Commission, membership and qualifications of members thereof, adequate and proper staffing procedures, rating bureaus, hearings, and deviations, the taxation of insurance companies and/or insurance company products, the cost of premiums, rating factors, actuaries, management of state and local insurance matters, problems experienced by the consuming public, premiums paid, all types of bonds and bonding, insurance agents, brokers, salesmen and stockholders, executives, employees and personnel, including experts, claims processing payment and associated procedures, assignment of claims to professionals, hospitals, standardization, investments of insurance companies, lending, admitted assets, and all matters relating to financial solvency, reserves or capital of insurance companies, licensing and capitalization of companies, various products and offerings of any person or entity, which products have attributes and characteristics of insurance, securities, or any hybrid or blended product, and the assessment of regulatory and related costs, or any matter relating to insurance or insurance companies.

(6) Conduct public hearings in various parts of the state for the purpose of carrying out the provisions of this Part.

Acts 1990, No. 995, §1, eff. July 26, 1990.

§1450.4. Report to the legislature

A. The committee shall compile a definitive draft of a revised insurance code which shall be submitted to the legislature prior to the 1992 Regular Session together with explanatory statements and notes which state present law, assigned reasons for change, and explain each change or exception, and what it does, and provide other comments as may be appropriate, including revenue impact and estimates.

B. The committee shall compile a preliminary draft of suggested revisions to the insurance code which it deems appropriate for introduction in the 1991 Regular Session of the Legislature.

Acts 1990, No. 995, §1, eff. July 26, 1990.

§1450.5. Publication; draft

The proposed draft code recommended by the committee may be printed and published in a suitable form, as needed for official use and may be sold by the Legislative Document Rooms of the House and the Senate to the public at a price, to be fixed by the committee.

Acts 1990, No. 995, §1, eff. July 26, 1990.

§1450.6. Powers; subpoenas; contempt

The committee may require the presence of witnesses and documents by subpoena and conduct audits and other examinations related to the pursuit of its purposes. The committee may punish for contempt and file, intervene or otherwise participate in ancillary administrative or legal proceedings.

Acts 1990, No. 995, §1, eff. July 26, 1990.

§1450.7. Authority for staff; compensation

Subject to the approval of the president of the Senate and the speaker of the House of Representatives, the committee may use available legislative staff and may employ such persons, including experts, as they find necessary to carry out the provisions of this Part and to fix the compensation of technical, professional, and clerical employees as needed to complete the work. To defray the expenses of the committee and its activities incurred in the revision of the insurance code, the committee may receive donations from private sources. The members of the committee shall receive the per diem authorized for the members of the legislature.

Acts 1990, No. 995, §1, eff. July 26, 1990.

§1450.8. Advisory task force

A. The committee shall appoint an advisory task force with a representative from each of the following:

(1) A multiple line, national stock insurance company which is a subscriber to the American Agency System, which is not affiliated with any national trade association, and which is among the top ten nonauto liability writers in Louisiana.

(2) A domestic nonprofit health service and indemnity plan.

(3) A domestic commercial health insurer.

(4) Alliance of American Insurers.

(5) American Insurance Association.

(6) National Association of Independent Insurers.

(7) Independent Insurance Agents of Louisiana, Inc.

(8) Professional Insurance Agents Association of Louisiana.

(9) Louisiana Association of Fire and Casualty Companies.

(10) Louisiana Surplus Line Association.

(11) Property Insurance Association of Louisiana.

(12) Louisiana Insurers' Conference.

(13) New Orleans Insurance Executive Council.

(14) National Association of Life Insurance Companies.

(15) American Council of Life Insurance.

(16) Health Insurance Association of America.

(17) Louisiana Association of Life Underwriters.

(18) Louisiana Independent Administrators Association.

(19) Life Insurers' Conference.

(20) A multiple line, mutual national insurance company which is not a subscriber to the American Agency System and which is among the top three auto insurance writers in Louisiana.

B. The committee may also appoint other members to the advisory task force as it deems appropriate.

Acts 1990, No. 995, §1, eff. July 26, 1990.

PART XXX-B. TRANSPLANT CENTERS

§1450.21. Organ transplant centers

No health insurance issuer authorized to transact business in this state shall refuse to consider an application to provide solid organ transplantation in any preferred or exclusive provider network by any transplant center located in the state provided the following conditions are met:

(1) The transplant center team is certified by the United Network for Organ Sharing, for organ transplantation and certified under Title XVIII of the Social Security Act or in the absence of such certification, other appropriate standards utilized by the majority of health insurance issuers in this state.

(2) The transplant center is certified under Title XVIII of the Social Security Act or, in the absence of such certification, other appropriate standards utilized by a majority of health insurance issuers in this state.

(3) The transplant center accepts payment at the same rate paid to other transplant centers located outside of Louisiana with whom the health insurance issuer has a contract for such services.

(4) The transplant center agrees to perform all medically necessary services associated with a transplant at no additional cost to the insured or enrollee regardless of any lifetime benefit limits or other limitations on coverage.

Acts 1999, No. 207, §1.

§1450.22. Hematopoietic transplant centers

No health insurance issuer authorized to transact business in this state shall refuse to consider an application to provide hematopoietic cell transplantation in any preferred or exclusive provider network by any transplant center located in the state provided the following conditions are met:

(1) The transplant center is certified by the Federation for the Accreditation of Hematopoietic Cell Therapy (FAHCT) or by at least one of the following National Institutes of Health sponsored cooperative groups: the Southwest Oncology Group (SWOG), the Eastern Cooperative Oncology Group (ECOG), or the Cancer and Leukemia Group B (CALGB), for adult patients; and the Pediatric Oncology Group (POG) or Children's Cancer Group (CCG) for pediatric patients.

(2) The transplant center accepts payment at the same rate paid to other transplant centers located outside of Louisiana with whom the health insurance issuer has a contract for such services.

(3) The transplant center agrees to perform all medically necessary services associated with hematopoietic cell transplantation at no additional cost to the insured or enrollee regardless of any lifetime benefit limits or other limitations on coverage.

Acts 1999, No. 207, §1.

§1450.23. Documentation

A. The provisions of this Part shall not apply to a health insurance issuer who has documented to the satisfaction of the commissioner of insurance that inclusion of the Louisiana based transplant center will result in higher costs to the insurer and insured.

B. In reviewing any documentation provided by a health insurance issuer, the commissioner of insurance shall consider costs to the insured and family members for travel, the cost of services that will be provided by the instate transplant center that are not otherwise covered by the health plan and any differences in deductible, coinsurance, or copayment amounts. The commissioner of insurance shall consider any contractual or reinsurance costs associated with the cost of the inclusion of a transplant center located in Louisiana. The commissioner of insurance shall also consider the additional costs associated with the credentialing process, as well as additional administrative costs associated with contracting with the transplant center.

Acts 1999, No. 207, §1.

§1450.24. REPEALED BY ACTS 1997, No. 1116, §2.
§1450.25. REPEALED BY ACTS 1997, No. 1116 , §2.

PART XXXI. MISCELLANEOUS AND FINAL PROVISIONS

§1451. Annual reports required

A. Every insurer authorized to do business in this state shall annually and quarterly file with the commissioner of insurance a true statement of its financial condition, transactions, and affairs, as hereafter required. The statement shall be on forms and shall contain information as required by this Code and by the commissioner of insurance, including supplementals for additional information required by the commissioner of insurance, and shall be verified by the oaths of at least two of the insurer's principal officers. Statements shall also be filed on computer diskettes, as approved by the commissioner of insurance. The commissioner of insurance, under specific regulations promulgated by the commissioner, may annually waive the computer diskette reporting requirement.

B. The annual statement shall be due before the first day of March and show the condition of the company as of the thirty-first day of December preceding. The first quarterly report shall be due prior to May fifteenth and show the condition of the company as of the thirty-first day of March preceding. The second quarterly report shall be due prior to August fifteenth and show the condition of the company as of the thirtieth day of June preceding. The third quarterly report shall be due prior to November fifteenth and show the condition of the company as of the thirtieth day of September preceding.

C. The commissioner of insurance shall annually during November and December furnish each such insurer duplicate copies of annual and quarterly forms as next required to be filed.

D. Each such insurer shall file the appropriate National Association of Insurance Commissioners annual statement blank and quarterly statement blank, which shall be prepared in accordance with the National Association of Insurance Commissioners annual statement instructions handbook, and shall follow those accounting practices and procedures prescribed by the appropriate National Association of Insurance Commissioners Accounting Practices and Procedures Manual.

E. The annual and quarterly statement of an alien insurer shall relate only to its transactions and affairs in the United States unless the commissioner of insurance requires otherwise. The statement shall be verified by the insurer's United States manager or by its officers duly authorized.

F. The commissioner of insurance may suspend or revoke the certificate of authority of any insurer failing to file its annual statement when due or during any extension of time thereof which the commissioner of insurance, for good cause, may grant.

G. Unless it appears in the discretion of the commissioner that the condition of a small company renders the continuance of its business hazardous to the public or its insureds, a small company shall be exempted from the following filings required by this Section:

(1) Quarterly statements.

(2) Management discussion and analysis accompanying the annual statement.

(3) Computer diskette filings of the annual statement.

Acts 1958, No. 125; Acts 1992, No. 811, §1; Acts 1993, No. 558, §1; Acts 1999, No. 1304, §1, eff. July 12, 1999; Acts 1999, No. 1312, §1, eff. July 12, 1999.

§1451.1. REPEALED BY ACTS 1995, No. 729, §1.

§1451.2. REPEALED BY ACTS 1995, No. 729, §1.

§1451.3. Material transactions; report, domestic insurers

A. As used in this Section, the following terms shall have the following meanings:

(1) "Acquisition of assets" shall include any purchase, lease, exchange, merger, consolidation, succession, or other acquisition, other than the construction or development of immovable property, by or for the reporting insurer or the acquisition of materials for that purpose.

(2) "Disposition of assets" shall include any sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment, whether for the benefit of creditors or others, abandonment, destruction, or other disposition.

(3) "Material acquisition" or "material disposition" is an acquisition or disposition or the aggregate of any series of related acquisitions or dispositions during any thirty-day period which is nonrecurring, is not in the ordinary course of business, and involves more than five percent of the insurer's total admitted assets reported in the most recent quarterly or annual statement filed by the insurer with the department.

(4) "Material nonrenewal, cancellation, or revision" shall mean:

(a) For property and casualty insurers, including health and accident business written by a property and casualty insurer:

(i) More than fifty percent of the total ceded written premium by the insurer.

(ii) More than fifty percent of the total ceded indemnity and loss adjustment reserves by the insurer.

(b) For life, annuity, and health and accident insurers, more than fifty percent of the total reserve credit taken for the business ceded, on an annualized basis, as indicated in the most recent annual report of the insurer.

(5) "Material revision" for property and casualty or life, annuity, and health and accident insurers shall include the following:

(a) The replacement by one or more unauthorized reinsurers of an authorized reinsurer representing more than ten percent of a total cession.

(b) The reduction or waiver of previously established collateral requirements for one or more unauthorized reinsurers representing collectively more than ten percent of a total cession.

B.(1) Every domestic insurer shall file a report, including any exhibits or other attachments with the department and with the National Association of Insurance Departments disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements. No report shall be filed if the acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements have been submitted to the department for review, approval, or informational purposes for other provisions of the Louisiana Insurance Code, laws, regulations, or other requirements.

(2) No filing shall be required of ceded reinsurance agreements if:

(a) For property and casualty insurance, including accident and health business written by a property and casualty insurer, the total ceded written premium of the insurer represents on an annualized basis less than ten percent of its total written premium for direct and assumed business.

(b) For life, annuity, and accident and health insurance, the total reserve credit taken for business ceded represents on an annualized basis less than ten percent of the statutory reserve requirement prior to any cession.

C.(1) The report required in Subsection B of this Section is due within fifteen days after the end of the calendar month in which any of the foregoing transactions occur.

(2) The report shall be on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or one hundred percent reinsurance agreement that affects the solvency and integrity of the reserves of the insurer and the insurer ceded substantially all of its direct and assumed business to the pool.

(3) An insurer shall have ceded substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars total direct premiums, plus assumed written premiums, during a calendar year that are not subject to a pooling arrangement and which net income of the business not subject to the pooling arrangements represents less than five percent of the capital and surplus of the insurer.

D. All reports obtained by or disclosed to the department pursuant to this Section shall be given confidential treatment and shall not be subject to subpoena and shall not be made public by the department, the National Association of Insurance Departments, or any other person, except to insurance departments of other states, without the prior written consent of the reporting insurer. The department may disclose the report after giving the reporting insurer notice and an opportunity to be heard if it determines that the interest of policyholders, shareholders, or the public will be served by the publication of the report. The department may publish all or any part of the report in any form as the department may deem appropriate.

E. The following information shall be disclosed in any report of a material acquisition or disposition of assets:

(1) The date of the transaction.

(2) The manner of acquisition or disposition.

(3) The description of the assets involved.

(4) The nature and amount of the consideration given or received.

(5) The purpose or reason for the transaction.

(6) The manner by which the amount of consideration was determined.

(7) The gain or loss recognized or realized as a result of the transaction.

F. The following information shall be disclosed in any report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements:

(1) The effective date of the nonrenewal, cancellation, or revision.

(2) The description of the transaction with an identification of its initiator.

(3) The purpose of or reason for the transaction.

(4) The identity of the replacement insurer, if applicable.

Acts 1995, No. 1203, §1, eff. June 29, 1995.

§1452. Agreement on agents' compensation prohibited

No insurer shall enter into any combination or agreement with another insurer to prevent its legally authorized agents and representatives in this state from accepting a higher compensation than that paid by any party or parties to such agreement.

Acts 1958, No. 125.

§1453. Payments to adjusters limited; reciprocal fee; disposition of funds

A. No insurer shall pay to any insurance adjuster or adjusters or to any person engaged in the adjustment of losses any fee or compensation in excess of a regular fixed salary or stipend, nor shall such insurer contract to pay to any insurance adjuster or any person engaged in the business of adjusting losses, any portion of the amount saved to said insurer through the efforts of said adjuster or person engaged in adjusting losses, in addition to or in lieu of any such salary or stipend.

B.(1) An adjuster licensed by another jurisdiction other than this state, which jurisdiction imposes a tax, fee, license, bond, or deposit greater than that imposed by this state, shall pay a license fee equal to that of his state or country of licensure to the commissioner of insurance in order to perform his duties and responsibilities of adjusting a loss which occurred in this state.

(2) All funds collected by the commissioner of insurance shall be paid into the state treasury in the same manner as other funds collected by him.

(3) This Subsection shall not apply to adjusters permanently employed by any insurance company authorized to do business in this state.

Acts 1983, No. 474, §1.

§1454. Insurers prohibited from engaging in other businesses

No domestic insurer shall deal or trade in buying, or selling goods, wares or merchandise except articles insured by it on which losses are claimed and except in replacing, rebuilding, or repairing insured property as provided in its policies; nor discount commercial or other than first mortgage paper nor engage in any banking business whatsoever.

Acts 1958, No. 125.

§1455. REPEALED BY ACTS 1979, No. 255, §2

§1456. Particular provisions prevail

Provisions of this Code relating to a particular kind of insurance or a particular type of insurer or to a particular matter shall prevail over provisions relating to insurance in general, or to insurers in general, or to such matter in general.

Acts 1958, No. 125.

§1457. Suspension or revocation of insurers' licenses; fines

A. The commissioner of insurance may refuse to renew, or may suspend, or revoke the certificate of authority of any insurer violating any of the provisions of this Code, or in lieu of suspension or revocation of a license duly issued, the commissioner may levy a fine not to exceed one thousand dollars for each violation per insurer, up to one hundred thousand dollars aggregate for all violations in a calendar year per insurer, when such violations, in his opinion, after a proper hearing, warrant the refusal, suspension, or revocation of such certificate, or the imposition of the fine. The commissioner of insurance is authorized to withhold fines imposed under this Section. Such hearing shall be held in the manner provided in Part XXIX.

B. The commissioner may deny, refuse to renew, suspend, or revoke any certificate of authority of any health insurer that writes a sub-line of health insurance or otherwise issues a health policy in the same sub-line in the state or for a citizen of the state within five years after it has ceased to write such sub-line of health insurance in the state. A sub-line of health insurance means a specified form of health benefit coverage, including but not limited to cancer, credit health, dental, disability income, dread disease, hospitalization, long-term care medical expense insurance.

Acts 1958, No. 125. Amended by Acts 1964, No. 147, §1; Acts 1991, No. 517, §1; Acts 1993, No. 663, §2, eff. June 16, 1993.

§1458. Duration of licenses

All licenses issued to foreign or domestic insurers of any kind, including fraternal benefit societies, agents, sub-agents, solicitors, brokers, and all other persons shall remain in effect until cancelled, suspended, revoked, or the renewal thereof refused, provided all requirements of this Title relating to such insurers or persons are met.

Acts 1958, No. 125. Amended by Acts 1964, No. 145, §1, effective Jan. 1, 1965; Acts 2003, No. 136, §1.

§1459. Agents' compensation

A. In order to prevent unfair discrimination by any stock fire insurer in the compensation to be paid to its local agents in this state, each stock fire insurer shall annually on or before the first day of December of each year file with the fire insurance division of the Louisiana insurance rating commission a schedule of rates as well as all other compensation whatever which each insurer will pay its respective local agents within this state for the ensuing calendar year, provided that the said rate of commission, as well as all other compensation to be paid by each insurer shall be uniform and equal as to all of the local agents of said insurer throughout this state.

B. The commission paid by each casualty, surety, fidelity, guaranty and bonding insurer doing business in this state to its agents in this state, shall be uniform and equal as to all classes of agents of said insurer throughout this state.

Acts 1958, No. 125.

§1460. Signature of agent

Every duly licensed insurance agent who solicits information to be contained on any application for individual life or individual, family group or association health and accident insurance shall affix his legal signature thereto. No such agent shall sign any application described above unless he personally obtained the information shown on such application. Such information may be obtained by the agent in person, by telephone, or by any other means of direct communication between the agent and the applicant.

Added by Acts 1966, No. 178, §1; Acts 2003, No. 129, §1, eff. May 28, 2003; Acts 2003, No. 410, §1.

§1461. Prior approval required before a domestic insurer may apply for admission to another state or country

No domestic insurer may apply for admission to another state or country without first having obtained the approval of the commissioner of insurance of the state of Louisiana. Such approval shall not be withheld unless such application would be detrimental to the policyholders of the state of Louisiana or threaten the financial solvency of the company.

Added by Acts 1976, No. 454, §1.

§1461.1. Change of state of domicile of admitted insurer; conversion to foreign insurer; effects of redomestication

A. Any insurer which is organized under the laws of any other state and is admitted to do business in this state for the purpose of writing insurance may, upon approval of the commissioner of insurance, become a domestic insurer by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a place in this state. The domestic insurer shall be entitled to like certificates and licenses to transact business in Louisiana and shall be subject to the authority and jurisdiction of this state.

B. Any domestic insurer may, upon the approval of the commissioner of insurance, transfer its domicile to any other state in which it is admitted to transact the business of insurance and, upon such a transfer, shall cease to be a domestic insurer and shall be admitted to this state if qualified as a foreign insurer. The commissioner of insurance may approve any such proposed transfer unless he determines such transfer to not be in the interest of the policyholders of this state.

C. The certificate of authority, agents, appointments and licenses, rates, and other items which the commissioner of insurance allows, in his discretion, which are in existence at the time any insurer licensed to transact the business of insurance in this state transfers its corporate domicile to this or any other state by merger, consolidation, or any other lawful method shall continue in full force and effect upon such transfer if such insurer remains duly qualified to transact the business of insurance in Louisiana. All outstanding policies of any transferring insurer shall remain in full force and effect and need not be endorsed as to the new name of the company or its new location unless so ordered by the commissioner of insurance. Every transferring insurer shall file new policy forms with the commissioner of insurance on or before the effective date of the transfer but may use existing policy forms, with appropriate endorsements, if allowed by and under such conditions as approved by the commissioner of insurance. However, every such transferring insurer shall notify the commissioner of insurance of the details of the proposed transfer and shall promptly file any resulting amendments to corporate documents which are filed or required to be filed with the commissioner of insurance.

D. The commissioner may refuse any redomestication pursuant to this Section if the insurer has ceased writing a sub-line of health insurance or otherwise issues a policy in the same sub-line in the state within the prior five years.

Acts 1988, No. 165, §1, eff. June 29, 1988; Acts 1993, No. 663, §2, eff. June 16, 1993.

§1462. REPEALED BY ACTS 1992, NO. 707, §1.

§1462.1. False or fraudulent material information

A. It shall be unlawful for any person to intentionally and knowingly supply false or fraudulent material information pertaining to any document or statement required by the Department of Insurance.

B. Whoever violates the provisions of this Section shall be imprisoned, with or without hard labor, for not more than five years, or fined not more than five thousand dollars, or both.

Acts 1992, No. 464, §1.

§1463. REPEALED BY ACTS 1992, NO. 707, §1.

§1464. Property, casualty, and liability insurance; premium increase by insurer without or with material change in circumstances of insured; notice of premium increase

A.(1) No insurer shall be entitled to an additional premium for a commercial property, casualty, or liability insurance policy which has been in effect for more than ninety days or for a noncommercial property, casualty, or liability insurance policy which has been in effect for more than sixty days when there has been no material change in the circumstances of the insured from those stated by the insured in his application for the policy. The insured must receive a billing notice from the company or its agent within the first sixty days of the effective date of the policy for the company to be entitled to the additional premium. If the company or agent fails to bill the insured within the first sixty days of the effective date of the policy, the insured shall not be responsible for payment of such additional premium, shall not be penalized for nonpayment of that additional premium, and his policy shall not be cancelled for failure to pay such additional premium.

(2) A notice of an additional premium for a commercial property, casualty, or liability insurance policy which has been in effect for less than ninety days or for a noncommercial property, casualty, or liability insurance policy which has been in effect for less than sixty days when there has been a material change in the circumstances of the insured from those stated by the insured in his application for the policy shall be mailed or delivered to the insured at least thirty days prior to the date that the additional premium is due.

B. In this Section, "material change" shall mean any change in any matter which, if stated on the application, would have resulted in a different initial premium for the policy.

C. Nothing in this Section shall be construed to prevent an insurer from making rate changes at subsequent renewal dates of the policy.

D. This Section does not apply to audit type policies where the actual premium is to be determined at a later date.

E. This Section does not apply to property subject to ratings by the Property Insurance Association of Louisiana.

Acts 1988, No. 359, §1, eff. Sept. 1, 1988; Acts 1989, No. 658, §1; Acts 1991, No. 769, §1; Acts 1993, No. 196, §1.

§1464.1. Homeowner's insurance; premium discounts

A. As used in this Section, the following terms shall have the following meanings:

(1) "Mobile home", "manufactured home", and "manufactured housing" means a structure, transportable in one or more sections, which, in the traveling mode, is eight body feet or more in width or forty body feet or more in length or, when erected on site, is three hundred twenty or more square feet and which is built on a permanent chassis and designed to be used as a dwelling with or without a permanent foundation when connected to the required utilities and includes the plumbing, heating and air conditioning, and electrical systems contained therein.

(2) "Permanently structured home" means a structure with a permanent foundation that is not considered manufactured or mobile.

(3) "Security system" means a monitored security device that is wired to a local law enforcement or fire department.

B. Every insurer authorized to issue a policy of homeowner's insurance in this state who offers a policy premium discount based on the installation or existence of a security system in a permanently structured home shall provide the same or a similar premium discount for policies of homeowner's insurance covering mobile homes, manufactured homes, or manufactured housing.

Acts 1997, No. 185, §1.

§1465. Automobile insurance; substitute vehicle; notice of discontinuance; payment to provider

A. Whenever any policy of automobile insurance provides a substitute vehicle for an insured, the insurer shall continue its payment for the substitute vehicle until either seventy-two hours after the named insured has been notified that the insurer will cease such payment or until the cost or time limits which the policy provides for substitute vehicles have been met, whichever is earlier.

B. The notice provided by this Section shall not be required when the repair of the insured vehicle has been completed and the insured has received the repaired insured vehicle.

C. The notice provided by this Section shall not be required when the insured requests the discontinuance of the substitute vehicle provided by the insurer.

D. Whenever any policy of automobile insurance provides a substitute vehicle for an insured, the insurer shall guarantee payment at the request of the insured for use of such vehicle pursuant to the policy provisions and shall pay the provider of the vehicle directly for use of the substitute vehicle pursuant to the provisions of the policy.

Acts 1988, No. 944, §1; Acts 1992, No. 868, §1.

§1466. Motor vehicle insurance; consideration of nonfault incidents prohibited

A. No insurer shall increase the rate, increase or add a surcharge, cancel, or fail to renew any policy of motor vehicle insurance when such action is based on consideration of one or more nonfault incidents.

B. In this Section, "nonfault incident" means an accident, collision, or other incident involving a vehicle covered by a policy issued by the insurer in which the driver of the insured vehicle was not at fault, regardless of whether the incident was reported to any law enforcement agency.

C. Any insurer who violates this Section shall refund to the insured person the amount of premium which was paid which exceeded the premium which would have been charged if the insurer had complied with this Section, together with a penalty payment in amount equal to triple the amount of the refund or one thousand dollars, whichever is greater. The insured shall also be entitled to attorneys fees should he prevail.

D. Notwithstanding any other provision of law to the contrary, one or more nonfault accidents or collisions shall not be the sole basis for an insurer's denial of an application for a policy of motor vehicle insurance nor shall such an accident or collision be considered by an insurer in determining the rates for such a policy. In addition, no insurer shall require that such coverage be provided by another insurer based solely upon such an accident or collision.

Acts 1989, No. 578, §1; Acts 1992, No. 525, §1; Acts 1992, No. 832, §1.

§1467. Complaints against insurers; file by company; public information

A. The Department of Insurance shall file all complaints which it receives against a named insurer in a separate file for each insurer. This record shall be maintained in such a manner as to permit the public to readily ascertain information concerning complaints against insurance companies, without the necessity of reviewing each individual complaint. The commissioner of insurance shall avail himself of such computer equipment as he has available to perform this task.

B.(1) The record required by this Section shall contain information including but not limited to the following:

(a) Date of complaint.

(b) Name of the company against whom the complaint is lodged.

(c) Name of the complainant.

(d) Nature of the complaint.

(e) Action and findings by the department.

(f) Date of any such action.

(g) The response of the insurance company.

(2) The computer program employed by the commissioner shall, at a minimum, be able to sort the information in this database on any of the fields described in the preceding Paragraph and print out a written report thereof.

C. Failure to maintain this record in the manner prescribed herein shall constitute malfeasance on the part of the commissioner of insurance.

Acts 1990, No. 622, §1.

§1468. Attorney general; writ of mandamus

A. In any matter involving the enforcement of the provisions of this Title in which the attorney general deems that the commissioner of insurance is acting improperly, or failing to act in a manner requiring action, he may petition the 19th Judicial District Court for a writ of mandamus to compel the commissioner of insurance to act in the manner provided by law.

B. Any such petition for a writ of mandamus shall be tried by preference, and the court shall hear the matter and rule on it within three court days, unless the parties shall mutually agree to an extension thereof.

C. If the court is of the opinion that the public interest requires it, it shall grant the writ and order the commissioner of insurance to take such action as the court finds to be appropriate. Failure of the commissioner of insurance to comply with such an order shall be punishable as contempt.

Acts 1991, No. 383, §1, eff. July 6, 1991; Acts 1991, No. 984, §1, eff. July 24, 1991.

{{**NOTE**: SEE ACTS 1991, NO. 383, SECTION 1; R.S. 22:1468(D) PROVIDES FOR APPEAL BY WRIT APPLICATION TO THE SUPREME COURT.}}

§1469. Participation in the Insurance Regulatory Information System of the National Association of Insurance Commissioners

A.(1) Each domestic, foreign, or alien insurer who is authorized to transact insurance in this state shall file a copy of its annual statement convention blank, along with such additional filings as are prescribed by the commissioner for the preceding year, on or before March first of each year, with the National Association of Insurance Commissioners. The information filed with the National Association of Insurance Commissioners shall be in the same format and scope as that required by the commissioner and shall include the signed jurat page and the actuarial certification. Any amendments and addendums to the annual statement filing subsequently filed with the commissioner shall also be filed with the National Association of Insurance Commissioners.

(2) Foreign insurers that are domiciled in a state which has a law substantially similar to this Section shall be deemed in compliance with this Section.

B. In the absence of actual malice, members of the National Association of Insurance Commissioners, their duly authorized committees, subcommittees, and task forces, their delegates, employees of the National Association of Insurance Commissioners, and all others charged with the responsibility of collecting, reviewing, analyzing, and disseminating the information developed from the filing of the annual statement convention blanks shall be acting as agents of the commissioner under the authority of this Section and shall not be subject to civil liability for libel, slander, or any other cause of action by virtue of their collection, review, and analysis or dissemination of the data and information collected from such filings.

C. All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the Department of Insurance by the National Association of Insurance Commissioners Insurance Regulatory Information System shall be confidential and shall not be disclosed by the department.

D. The commissioner may suspend, revoke, or refuse to renew the certificate of authority of any insurer failing to file its annual statement when due or within any extension of time which the commissioner, for good cause, may have granted.

Acts 1991, No. 949, §1, eff. July 24, 1991.

§1470. Limits of risks assumed

No property and casualty insurer doing business in this state shall expose itself to loss on any one risk in an amount which exceeds ten percent of the insurer's capital and surplus. A risk, or any portion thereof, which has been reinsured shall be deducted in determining the limitation of risk prescribed in this Section.

Acts 1991, No. 960, §1; Acts 1992, No. 811, §1.

§1471. Homeowner's insurance; acts of God

No insurer shall cancel, fail to renew, or increase the amount of the premium, except upon an area-wide rating basis at the beginning of a new policy period, on a homeowner's policy of insurance based solely upon a loss caused by an "Act of God". An "Act of God" shall mean, in this Section, an incident due directly to natural causes and exclusively without human intervention.

Acts 1992, No. 70, §1.

§1472. Automobile policies; discrimination against paid or volunteer firemen prohibited

No insurer doing business in this state who issues a personal automobile insurance policy to an insured who is a paid or volunteer fireman shall charge a higher premium rate, increase or add a surcharge, cancel, or fail to renew a policy for the insured, based solely on the insured's activities as a paid or volunteer fireman.

Acts 1993, No. 41, §1; Acts 1995, No. 1098, §1.

§1473. Comparison data for automobile insurance policies

A. The Department of Insurance may compile computerized comparisons of premiums charged and coverage available for automobile insurance policies for typical individuals, families, and businesses, broken down by geographic area and by different deductible levels. The department may make such information available to consumers upon request and upon payment of a nominal fee designed to cover the cost of printing, but not of compiling or analyzing such data.

B. The department may prepare a comparison summary of automobile insurance rates for policies delivered or issued for delivery in this state and shall publish such summary twice annually in the official journal of this state.

C. The department may annually publish in pamphlet form, and make available to consumers, information useful to consumers in choosing automobile insurance coverage, including information about certain policy provisions of which consumers should be particularly careful.

Acts 1993, No. 959, §1.

§1474. Exclusive use of expirations

A.(1) Except as otherwise provided herein, for purposes of soliciting, selling, or negotiating the renewal or sale of insurance coverage, insurance products, or insurance services, an insurance agent or insurance broker shall have the exclusive use of expirations, records, or other written or electronic information directly related to an insurance application submitted by or an insurance policy written through an insurance agent or insurance broker. No insurance company, managing general agent, surplus lines insurance broker, wholesale broker, third party administrator, or residual markets including but not limited to the Louisiana Automobile Insurance Plan, the Louisiana Joint Reinsurance Plan, or the Louisiana Insurance Underwriting Plan, shall use such expirations, records, or other written or electronic information to solicit, sell, or negotiate the renewal or sale of insurance coverage, insurance products, or insurance services to the insured, either directly or by providing such information to others without the express written consent of the insurance agent or insurance broker.

(2) Such expirations, records, or other written or electronic information may be used to review an application, issue a policy, or for any other purpose necessary for placing such business through the insurance agent or insurance broker. Such expirations, records, or other written or electronic information may also be used for any other purpose which does not involve the soliciting, selling, or negotiating the renewal or sale of insurance coverage, insurance products, or insurance services.

B. This Section shall not apply:

(1) When the insured requests, individually or through another agent, that the insurance company renew the policy or write other insurance business.

(2) When the insurance agent has, by contract, agreed to act exclusively for one company or group of affiliated insurance companies, in which case the rights of the agent shall be determined by the terms of the agent's contract with that company or affiliated group.

(3) When the insurance agent or insurance broker is in default for nonpayment of premiums or other monies due and owing for which the agent is in default under the insurance agent's or insurance broker's contract or other agreement with the insurer, unless there is a legitimate dispute as to monies owed.

(4) When the agency contract is terminated and the insurance company is required by law to continue coverage for the insured; however, in that event, the insurance company shall continue to pay the insurance agent or insurance broker commissions on such policies that the company is required to renew during the thirty-six month period following the effective date of the termination or three years, whichever is sooner. The commission shall be at the insurer's prevailing commission rates in effect on the date of renewal for that class or line of business in effect on the date of renewal for brokers or agents whose contracts are not terminated.

(5) To policies providing life and health insurance.

C. The insurance agent or insurance broker and insurer may in a written agreement, separate from the agency contract, mutually agree to terms different than the provisions set forth in this Section. The terms of any such agreement shall be negotiated in good faith between the parties.

D.(1) The commissioner of insurance may adopt rules, in accordance with the Administrative Procedure Act, to enforce the provisions of this Section and any violation of this Section or the rules adopted thereunder shall be subject to regulation by the commissioner of insurance under R.S. 22:1457.

(2) In addition, the insurance agent or insurance broker shall have a right to a claim for lost commissions. Such claim shall be resolved in accordance with the dispute resolution terms in the applicable contract or agreement. In the absence of any dispute resolution term, the parties shall attempt to resolve their dispute through mediation. If the claim is not resolved through mediation, the claim may be resolved through binding arbitration if the parties agree. In the absence of an agreement to resolve the claim through binding arbitration, the agent or broker may maintain an action of lost commissions.

(3) Except as provided in this Section, nothing in this Section shall be interpreted as impairing any rights in law or contract currently enjoyed by any party.

Acts 1999, No. 1186, §1.

§1475. Life and health sales quotas; prohibitions

No existing contract between an insurer and an agent may be amended to add any provision that may require, as a quota, an agent to sell a specific number of life or health policies or a specific dollar amount of life or health insurance, unless that contract contains a provision requiring the agent to sell life or health insurance.

Acts 2001, No. 287, §1.

§1476. Public adjuster defined; contingent fee agreements; contrary to public policy

A. As used in this Section, "public adjuster" means an individual, except a duly licensed attorney at law, who, for compensation, acts on behalf of an insured or aides the insured in any manner in negotiating for or effecting the settlement of a claim for loss or damage resulting from an accident or other occurrence covered under an insurance policy that insures against loss or damage to property, or any person who advertises or solicits for employment as an adjuster of such claims.

B. Any contract or arrangement between an insured and a public adjuster which provides for payment of a fee to the public adjuster which is contingent upon, and calculated as a percentage of, the amount of any claim or claims paid to, or on behalf of an insured by the insurer shall be against public policy and is null and void.

Acts 2003, No. 148, §1.

PART XXXI-A. USE OF CREDIT INFORMATION

§1481. Purpose

The purpose of this Part is to regulate the use of credit information for personal insurance so that consumers are afforded certain protections with respect to the use of such information.

Acts 2003, No. 1256, §1.

§1482. Scope

This Part applies to personal insurance and not to commercial insurance. For purposes of this Part, "personal insurance" means private passenger automobile, homeowners, motorcycle, mobile home owners, and noncommercial dwelling fire insurance policies and boat, personal watercraft, snowmobile, and recreational vehicle policies. Such policies must be individually underwritten for personal, family, or household use. No other type of insurance shall be included as personal insurance for the purposes of this Part.

Acts 2003, No. 1256, §1.

§1483. Definitions

For the purposes of this Part, the following terms shall have the following meanings:

(1) "Adverse action" means a denial or cancellation of, an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of any insurance, existing or applied for, in connection with the underwriting of personal insurance.

(2) "Affiliate" means any company that controls, is controlled by, or is under common control with another company.

(3) "Applicant" means any individual who has applied to be covered by a personal insurance policy with an insurer.

(4) "Consumer" means an insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of a personal insurance policy or an applicant for such a policy.

(5) "Consumer reporting agency" means any person which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

(6) "Credit information" means any credit-related information derived from a credit report, found on a credit report itself, or provided on an application for personal insurance. Information that is not credit related shall not be considered "credit information", regardless of whether it is contained in a credit report or in an application, or is used to calculate an insurance score.

(7) "Credit report" means any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing, or credit capacity which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor to determine personal insurance premiums, eligibility for coverage, or tier placement.

(8) "Insurance score" means a number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured.

Acts 2003, No. 1256, §1.

§1484. Use of credit information

An insurer authorized to do business in Louisiana that uses credit information to underwrite or rate risks shall not:

(1) Use an insurance score that is calculated using income, gender, address, zip code, ethnic group, religion, marital status, or nationality of the consumer as a factor.

(2) Deny, cancel, or nonrenew a policy of personal insurance solely on the basis of credit information, without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by Paragraph (1) of this Section.

(3) Base an insured's renewal rates for personal insurance solely upon credit information, without consideration of any other applicable factor independent of credit information.

(4) Take an adverse action against a consumer solely because he does not have a credit card account or other credit history, without consideration of any other applicable factor independent of credit information.

(5) Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance, unless the insurer does one of the following:

(a) Treats the consumer as otherwise approved by the commissioner, if the insurer presents information that such an absence or inability relates to the risk by the insurer.

(b) Treats the consumer as if the applicant or insured had neutral credit information, as defined by the insurer.

(c) Excludes the use of credit information as a factor and uses only other underwriting criteria.

(6) Takes an adverse action against a consumer based on credit information, unless an insurer obtains and uses a credit report issued or an insurance score calculated within one hundred and eighty days from the date the policy is first written or renewal is issued.

(7) Uses credit information unless not later than every thirty-six months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report. Regardless of the requirements of this Paragraph:

(a) At annual renewal, upon the request of a consumer or the consumer's agent, the insurer shall re-underwrite and re-rate the policy based upon a current credit report or insurance score. An insurer need not recalculate the insurance score or obtain the updated credit report of a consumer more frequently than once in a twelve-month period.

(b) The insurer shall have the discretion to obtain current credit information upon any renewal before thirty-six months, if consistent with its underwriting guidelines.

(c) No insurer need obtain current credit information for an insured, notwithstanding the requirements of Subparagraph (a) of this Paragraph, if one of the following applies:

(i) The insurer is treating the consumer as otherwise approved by the commissioner.

(ii) The insured is in the most favorably priced tier of the insurer or group of affiliated insurers; however, the insurer shall have the discretion to order such report, if consistent with its underwriting guidelines.

(iii) Credit was not used for underwriting or rating such insured when the policy was initially written; however, the insurer shall have the discretion to use credit for underwriting or rating such insured upon renewal, if consistent with its underwriting guidelines.

(iv) The insurer reevaluates the insured beginning no later than thirty-six months after inception and thereafter based upon other underwriting or rating factors, excluding credit information.

(v) The insurer provides a documented offer to the insured on an annual basis of the insured's right to voluntarily request that their insurance credit score be rerun and reevaluated based on the current information available at the time of the insured's request.

(d) For personal policies in place prior to August 15, 2003, the insurer shall begin reevaluating renewal policies in compliance with this Section no later than thirty-six months from August 15, 2003, unless otherwise requested in accordance with Subparagraph (a) of this Paragraph or otherwise not required under Subparagraph (c) of this Paragraph.

(8) Use the following as a negative factor in any insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a policy of personal insurance:

(a) Credit inquiries requested by the consumer for his own credit information, or inquiries not initiated by the consumer, including promotional inquiries, periodic inquiries by existing credit providers, and credit system administration inquiries.

(b) Inquiries relating to insurance coverage, if so identified on a consumer's credit report.

(c) Collection accounts with a medical industry code, if so identified on the consumer's credit report.

(d) Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the home mortgage industry and made within thirty days of one another, unless only one inquiry is considered.

(e) Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the automobile lending industry and made within thirty days of one another, unless only one inquiry is considered.

(f) The extension of available credit in excess of what the insurer deems reasonable, when the consumer has an otherwise acceptable credit history and does not present an increased underwriting or rating risk.

(9) Create unreasonable disparities between underwriting tier placement between different lines of personal insurance for the same applicant solely on the basis of credit information unless justified by actuarial or statistical data or sound underwriting criteria, without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by Paragraph (1) of this Section.

Acts 2003, No. 1256, §1.

§1485. Dispute resolution and error correction

If it is determined through the dispute resolution process set forth in the federal Fair Credit Reporting Act, 15 U.S.C. 1681i(a)(5) that the credit information of a current insured was incorrect or incomplete and if the insurer receives notice of such determination from either the consumer reporting agency or from the insured, the insurer shall re-underwrite and re-rate the consumer within thirty days of receiving the notice. After re-underwriting or re-rating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines. If an insurer determines that the insured has overpaid premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last twelve months of coverage or the actual policy period.

Acts 2003, No. 1256, §1.

§1486. Appeals of underwriting or rates

Insurers using credit information to underwrite or rate risks shall provide a process for the consumer to appeal the underwriting or rating of risks for which credit scoring may be an inappropriate factor. Nothing in this Section shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this Section.

Acts 2003, No. 1256, §1.

§1487. Exemptions from the use of credit information

Insurers shall provide reasonable exemptions from the use of credit information in underwriting or rating risks if the consumer can clearly demonstrate that his credit history is unduly influenced by a medical crisis, death of a spouse, identity theft, the personal guaranty of a business loan, or a catastrophic event as deemed by the commissioner of insurance. Nothing in this Section shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this Section.

Acts 2003, No. 1256, §1.

§1488. Initial notification

A. If an insurer writing personal insurance uses credit information in underwriting or rating a consumer, the insurer or its agent shall disclose, either on the insurance application or at the time the insurance application is taken, that it may obtain credit information in connection with such application. Such disclosure shall be either written or provided to an applicant in the same medium as the application for insurance. The insurer need not provide the disclosure statement required under this Section to any insured on a renewal policy, if such consumer has previously been provided a disclosure statement.

B. Use of the following example disclosure statement constitutes compliance with this Section: "In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score."

Acts 2003, No. 1256, §1.

§1489. Adverse action notification

If an insurer takes an adverse action based upon credit information, the insurer must meet the notice requirements of this Section. Such insurer shall:

(1) Provide notification to the consumer that an adverse action has been taken in accordance with the requirements of the federal Fair Credit Reporting Act, 15 U.S.C. 1681m(a).

(2) Provide notification to the consumer explaining the reason for the adverse action. The reasons shall be provided in sufficiently clear and specific language so that a person can identify the basis for the insurer's decision to take an adverse action. Such notification shall include a description of up to four factors that were the primary influences of the adverse action. The use of generalized terms such as "poor credit history", "poor credit rating", or "poor insurance score" does not meet the explanation requirements of this Section. Standardized credit explanations provided by consumer reporting agencies or other third-party vendors are deemed to comply with this Section.

Acts 2003, No. 1256, §1.

§1490. Filing

A. Insurers that use insurance-related scoring systems to underwrite and rate risks shall file their scoring models or other scoring processes with the Department of Insurance. A third party may file scoring models on behalf of insurers. A filing that includes insurance scoring may include loss experience justifying the use of credit information.

B. Any filing relating to credit information is considered a trade secret under R.S. 51:1431.

Acts 2003, No. 1256, §1.

§1491. Indemnification

A. An insurer shall indemnify, defend, and hold producers harmless from and against all liability, fees, and costs arising out of or relating to the actions, errors, or omissions of a producer who obtains or uses credit information or insurance scores for an insurer, provided the producer follows the instructions of or procedures established by the insurer and complies with any applicable law or regulation.

B. An insurer or credit information provider shall not require a producer to indemnify or hold them harmless, except to the extent of the producer's negligent failure to comply with procedures established by the insurer or credit information provider. An insurer shall not evaluate or compensate a producer based upon the customer credit scores submitted by the producer. An insurer using credit information for underwriting or rating purposes shall provide appropriate training to its producers.

C. Nothing in this Section shall be construed to provide a consumer, agent, or other insured with a cause of action that does not exist in the absence of this Section.

Acts 2003, No. 1256, §1.

§1492. Sale of policy term information by consumer reporting agency

A. No consumer reporting agency or insurer shall provide or sell dates or lists that include any information that in whole or in part was submitted in conjunction with an insurance inquiry about a consumer's credit information or a request for a credit report or insurance score. Such information includes but is not limited to the expiration dates of an insurance policy or any other information that may identify time periods during which a consumer's insurance may expire and the terms and conditions of the consumer's insurance coverage.

B. The restrictions provided in Subsection A of this Section do not apply to data or lists the consumer reporting agency or insurer supplies to the insurance producer from whom information was received, the insurer on whose behalf such producer acted, or such insurer's group, affiliates, or holding companies.

C. Nothing in this Section shall be construed to restrict any insurer from being able to obtain a claims history report or a motor vehicle report.

Acts 2003, No. 1256, §1.

§1493. Severability

If any portion of this Part is declared invalid due to an interpretation of or a future change in the federal Fair Credit Reporting Act, the remaining parts thereof shall be in no manner affected thereby but shall remain in full force and effect.

Acts 2003, No. 1256, §1.

§1494. Applicability

This Part shall apply to personal insurance policies either written to be effective or renewed on or after nine months from August 15, 2003.

Acts 2003, No. 1256, §1.

PART XXXII. SEPARATE ACCOUNTS

§1500. Separate accounts and contracts issued in connection therewith

A. Any domestic life insurance company may establish one or more separate accounts, and may allocate to such separate account or accounts any amounts paid to or retained by the company which are to be applied under the terms of an individual or group contract to provide for life insurance, annuities, and other benefits incidental thereto, payable in fixed or in variable dollar amounts or in both.

B. To the extent such company deems it necessary to comply with the Investment Company Act of 1940, the Securities Exchange Act of 1934, and other applicable federal laws, as such acts are and may be amended, such company may, with respect to any separate account or any portion thereof, including without limitation any separate account which is a management investment company or a unit investment trust, provide for the benefit of persons having beneficial interest therein special voting and other rights and special procedures for the conduct of the business and affairs of such separate account or portion thereof, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and the selection of a committee, the members of which need not be otherwise affiliated with such company, to manage the business and affairs of such separate account or portion thereof.

C. The amounts allocated to each such account and accumulations thereon may be invested and reinvested in any class of investments which are authorized by Subsections A through and including G of R.S. 22:844, except that the quantitative limitations contained in such Subsections A through G of R.S. 22:844 shall not apply to investments of amounts allocated to each such separate account; provided however, notwithstanding any of the restrictions or limitations contained in said Subsections A through G of R.S. 22:844 all of such amounts allocated to a separate account and accumulations thereon may be invested in the shares of an open-end investment company or companies registered under the Federal Investment Company Act of 1940; provided further, that to the extent that the company's reserve liability with regard to (1) benefits guaranteed as to dollar amount and duration and (2) funds guaranteed as to principal amount or stated rate of interest is maintained in any such separate account, a portion of the assets of such separate account at least equal to such reserve liability shall be invested in accordance with the quantitative and qualitative requirements of Part XVIII of Chapter 1 governing the investments of life insurance companies. The investments in such separate account or accounts shall not be taken into account in applying the investment limitations applicable to other investments of the company.

D. The income, if any, and gains and losses, realized or unrealized, on each account shall be credited to or charged against the amounts allocated to the account in accordance with the contract, without regard to other income, gains or losses of the company.

E. That portion of the assets of any separate account equal to the reserves and other contract liabilities with respect to such account, if and to the extent so provided in the applicable contracts, shall not be chargeable with liabilities arising out of any other insurance business the company may conduct. Any portion of the assets in excess of such reserves and other contract liabilities shall be chargeable with liabilities arising out of any other insurance business the company may conduct.

F.(1) Amounts allocated to a separate account in the exercise of the power granted by this Section shall be owned by the company, and the company shall not be, or hold itself out to be, a trustee with respect to such amounts.

(2) Notwithstanding the provisions of Paragraph (1) of this Subsection, all assets of a separate account shall be deemed subject to a security interest granted by the company in favor of the holders of that separate account, to secure any and all of the company's obligations to such account holders. This security interest shall be deemed for any and all purposes to constitute a security interest arising by operation of law. This security interest need not be reflected in writing or comply with the provisions of R.S. 10:8-101 et seq., R.S. 10:9-101 et seq., Civil Code Art. 3158, or R.S. 9:4321 et seq. The company's continued possession or control of such assets, as well as its continued ability to withdraw or substitute assets of such separate account at will, shall not be deemed to adversely affect the validity of the security interest provided hereunder. If delinquency proceedings are brought by or against the company, the security interest hereby granted shall continue to be recognized for all purposes, including but limited to liquidation of the company under the provisions of R.S. 22:761(E).

G. Unless otherwise approved by the commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then in accordance with uniform, nondiscriminatory standards applicable to the separate account assets or in accordance with the terms of the applicable contract; provided that, unless otherwise approved by the commissioner, the portion of the assets of such separate account at least equal to the company's reserve liability with regard to the guaranteed benefits and funds referred to in Subsection C hereof, if any, shall be valued in accordance with the rules otherwise applicable to the company's assets.

H. If the contract provides for payment of benefits in variable amounts, it shall contain a statement of the essential features of the procedure to be followed by the company in determining the dollar amount of such variable benefits. Any such contract, including a group contract, and any certificates issued thereunder, shall state that such dollar amount may decrease or increase and shall contain on its first page a statement that the benefits thereunder are on a variable basis. The insurance commissioner, where appropriate, may require an annuity contract to provide a determinable cash value. The company issuing a contract on a variable basis shall furnish each contract holder with annual reports of the financial condition of the separate account, in such form as the insurance commissioner shall prescribe.

I. No domestic life insurance company, and no other life insurance company admitted to transact business in this state, shall be authorized to deliver within this state any contract providing benefits in variable amounts until said company has satisfied the commissioner that its condition or methods of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this state. In determining the qualifications of a company requesting authority to deliver such contracts within this state, the commissioner shall consider, among other things:

(1) The history and financial condition of the company;

(2) The character, responsibility and general fitness of the officers and directors of the company; and

(3) In the case of a company other than a domestic company, whether the statutes and regulations of the jurisdiction of its incorporation provide a degree of protection to policyholders and the public which is substantially equal to that provided by this section and the rules and regulations issued thereunder.

An authorized life insurance company, whether domestic, foreign, or alien, which issues contracts providing benefits in variable amounts and which is a subsidiary of (or affiliated through common management or ownership with) another life insurance company authorized to do business in this state may be deemed to have met the provisions of this subsection if either it or the parent or affiliated company meets the requirements hereof.

J. The insurance commissioner shall have the sole and exclusive authority to regulate the issuance and sale of such contracts and to issue such reasonable rules and regulations as may be necessary to carry out the purposes and provisions of this Part XXXII of Chapter 1 of Title 22, Louisiana Revised Statutes; and such contracts, the companies which issue them and the agents or other persons who sell them shall not be subject to the provisions of Part X of Title 51 of the Louisiana Revised Statutes of 1950 nor to the jurisdiction of the Louisiana commissioner of securities.

K. Except for R.S. 22:173A(1), 173A(6), and 173A(7) in the case of a variable annuity contract and R.S. 22:170A(1), 170A(7), and 170A(9), R.S. 22:166, 22:167, 22:168, and 22:169 in the case of an individual variable life insurance contract and R.S. 22:176(3) in the case of a group variable life insurance contract and except as otherwise provided in this Part, all pertinent provisions of the insurance laws of this state shall apply to separate accounts and contracts relating thereto. Any individual variable life insurance contract, delivered or issued for delivery in this state shall contain grace, reinstatement and nonforfeiture provisions appropriate to such a contract; any such group variable life insurance contract shall contain a grace provision appropriate to such a contract and any such variable annuity contract shall contain grace, reinstatement and nonforfeiture provisions appropriate to such a contract.

Added by Acts 1966, No. 332, §§1, 2. Amended by Acts 1968, No. 61, §1; Acts 1976, No. 288, §1; Acts 1993, No. 785, §1.

PART XXXIII. DENTAL SERVICE CONTRACTORS

§1510. Definitions

For the purposes of this Part, the following words and phrases shall be defined as follows:

(1) "Dentist" means any person lawfully licensed by the Louisiana State Board of Dentistry to practice dentistry in Louisiana.

(2) "Dental service contractor" means any person who accepts a prepayment from or for the benefit of any other person or group of persons as consideration for providing to such person or group of persons the opportunity to receive dental services at such times in the future as such services may be appropriate or required, but shall not be construed to include a dentist or professional dental corporation that accepts prepayment on a fee-for-service basis for providing specific dental services to individual patients for whom such services have been prediagnosed. Nothing in Paragraph 2 of this Section shall apply to a funded or self-funded trust qualified with the United States Department of Labor in accordance with Public Law 93-406.

(3) "Participant" means a dentist who has contracted with a dental service contractor to accept from and to look solely to such contractor for payment for any health care services rendered to a subscriber, subject to any co-payment obligations included in the contract of the subscriber with the dental service contractor.

(4) "Commissioner" means the commissioner of insurance of the state of Louisiana.

(5) "Subscriber" means any person by or for whom a dental service contractor is paid a periodic premium as prepayment for dental services to be rendered to him by a participant.

(6) "Person" means an individual, insurer, association, organization, partnership, business, trust, except E.R.I.S.A. trusts qualified with the United States Department of Labor under Public Law 93-406, corporation, or other legal entity.

Added by Acts 1981, No. 461, §1.

§1511. Qualification and regulation of dental service contractors

A. No person shall act as or hold himself out to be a dental service contractor in this state unless that person has qualified and has been issued a certificate of authority as a domestic insurer or has been admitted to transact business in this state and issued a certificate of authority as a foreign or alien insurer under this Title.

B. Except as provided in this Part, every dental service contractor operating in this state shall be regulated by the commissioner as a domestic or foreign health and accident insurer and shall meet all of the requirements established by this Title applicable to health and accident insurers, including all capital, surplus, and deposit requirements. For purposes of regulation, a contract between a dental service contractor and a subscriber shall be considered a health and accident insurance policy, and the subscriber shall be considered a policyholder. Any insurer not authorized to transact any health and accident insurance business in this state which seeks authority to act also as a dental service contractor, shall be required to satisfy the capital, surplus, and deposit requirements referred to above in addition to those required to transact the business of insurance, and no cash or its equivalence and no bond used by an insurer to meet the capital, surplus, or deposit requirements of this Title to transact insurance shall be considered by the commissioner in determining whether that insurer is also qualified to act as a dental service contractor.

Added by Acts 1981, No. 461, §1.

§1512. Additional regulations

A. Each contract between a dental service contractor and its subscribers shall be nonassessable, shall have a minimum term of six months, and shall guarantee unconditionally to the subscriber the performance of all dental services covered by the contract and that those services shall be available and conveniently accessible, promptly as appropriate, and in a manner which assures continuity. The premium to be paid by the subscriber to the dental service contractor shall be set in the contract and shall not vary during the term of the contract.

B. Each contract between a dental service contractor and any of its participants for the rendition of services to subscribers shall provide that the contract may be cancelled by either the participant or the dental service contractor upon thirty days' written notice to the other party, and such cancellation shall be fully effective as to subscribers as well as to the other party to the contract.

Added by Acts 1981, No. 461, §1.

§1513. Freedom of choice of dentist in health plans

A. As used in this Section:

(1) "Dental care services" means any services furnished to any person for the purpose of preventing, alleviating, curing or healing human dental abnormalities, accidents, or diseases.

(2) "Dentist" means any person who furnishes dental care services and who is licensed as a dentist by the state of Louisiana.

(3) "Employee benefit plan" means any plan, fund, or program heretofore or hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, dental care benefits in the event of abnormality, accident, or dental disease.

(4) "Health insurance policy" means any individual, group, blanket, or association insurance policy, insurance agreement, or group hospital service contract providing benefits for dental care expenses incurred as a result of an abnormality, accident, or dental disease.

B.(1) No health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state shall:

(a) Prevent any person who is a party to or beneficiary of any such health insurance policy or employee benefit plan from selecting the dentist of his choice to furnish the dental care services offered by the policy or plan, or interfere with such selection.

(b) Deny any dentist the right to participate as a contracting provider for such policy or plan.

(c) Authorize any person to regulate, interfere, or intervene in any manner in the diagnosis or treatment rendered by a dentist to his patient.

(d) Require that any dentist make or obtain dental x-rays or any other diagnostic aids; however, nothing herein shall prohibit requests for existing dental x-rays or any other existing diagnostic aids for the purpose of determining benefits payable under a health insurance policy or employee benefit plan.

(2) Nothing herein shall prohibit the predetermination of benefits for dental care expenses prior to treatment by the attending dentist.

C. Any health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state, to the extent that it provides benefits for dental care expenses, shall:

(1) Disclose, if applicable, that the benefit offered is limited to the least costly treatment.

(2)(a) Define and explain the standard upon which the payment of benefits or reimbursement for the cost of dental care services is based, such as "usual and customary", "reasonable and customary", "usual customary and reasonable" fees or words of similar import, or shall specify in dollars and cents the amount of the payment or reimbursement for dental care services to be provided.

(b) The payment or reimbursement for a noncontracting provider dentist shall be the same as or greater than the payment or reimbursement for a contracting provider dentist; however, the health insurance policy or the employee benefit plan shall not be required to make payment or reimbursement in an amount that is greater than the amount so specified in the policy or plan or that is greater than the fee charged by the providing dentist for the dental care services rendered.

D. Any provision in a health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state which is contrary to this Section shall, to the extent of such conflict, be void.

E. The provisions of this Section shall not be deemed to mandate that any type of benefits for dental care expenses be provided by a health insurance policy or an employee benefit plan.

F. Notwithstanding any other provision of this Section:

(1) A dentist or a professional dental corporation as authorized under the provisions of R.S. 12:981, et seq. may contract directly with a patient for the furnishing of dental care services to the patient as may be otherwise authorized by law.

(2) Any person providing a health insurance policy or employee benefit plan, any employer, or any employee organization may:

(a) Make available to its insureds, beneficiaries, participants, employees, or members information relating to dental care services by the distribution of factually accurate information regarding dental care services, rates, fees, location, and hours of service, provided such distribution is made upon the request of any dentist licensed by this state.

(b) Establish an administrative mechanism which facilitates payment for dental care services by insureds, beneficiaries, participants, employees, or members to the dentist of their choice.

(c) Pay or reimburse, on a nondiscriminatory basis, its insureds, beneficiaries, participants, employees, or members for the cost of dental care services rendered by the dentist of their choice.

G. The provisions of this Section shall not apply to health insurance policies and employee benefit plans issued before July 12, 1985.

Acts 1985, No. 441, §1, July 12, 1985; Acts 2003, No. 129, §1, eff. May 28, 2003; Acts 2004, No. 607, §1.

§1513.1. Denial of claims

A dental service contractor or a contract of dental insurance shall establish and maintain appeal procedures for any claim by a dentist or a subscriber that is denied based upon lack of medical necessity. Any such denial shall be based upon a determination by a dentist who holds a nonrestricted license in the same or an appropriate specialty that typically manages the dental condition, procedure, or treatment under review. Subsequent to an initial denial, the dentist making the adverse determination shall not be an employee of the dental service contractor or dental insurer.

Acts 2003, No. 294, §1.

PART XXXIV. BAIL ENFORCEMENT AGENTS

§1514. Regulation of bail enforcement agents

A. The commissioner of insurance is hereby authorized to adopt such regulations, in accordance with the Administrative Procedure Act, as are necessary to effectuate the requirements of this Part to regulate bail enforcement agents.

B. The regulations adopted by the commissioner shall include provisions governing:

(1) Prelicensing and continuing education requirements for bail enforcement agents.

(2) Bail enforcement activities in this state by nonresident individuals.

(3) The notification of local law enforcement agencies.

(4) In-state bail enforcement procedures.

(5) Penalties for the violation of the regulation.

Acts 1999, No. 1037, §1.

§1514.1. Definitions

As used in this Part:

(1) "Bail enforcement" means the apprehension or surrender of a person who is released on bail or who has failed to appear at any stage of the proceedings to answer the charge before the court in which he may be prosecuted.

(2) "Bail enforcement agent" means a person who engages in bail enforcement.

Acts 1999, No. 1037, §1.

§1514.2. Licensing and fees

Except as provided by the regulations authorized in this Part, bail enforcement agents shall be subject to the same licensing and fee requirements as bail bond insurance agents.

Acts 1999, No. 1037, §1.

§1514.3. Bond producers; prohibitions; penalties

A. A bail bond producer may not engage in any of the following prohibited acts:

(1) Pay a fee or rebate or give or promise anything of value to a jailer, police officer, peace officer, or committing magistrate or any other person who has power to arrest or hold in custody or to any public official or public employee in order to secure a client, bailee, settlement, compromise, remission, or reduction of the amount of any bail bond.

(2) Pay a fee or rebate or give or promise anything of value to an attorney in a bail bond matter, except in defense of any action on a bond or for representation at a bail bond hearing. Whenever a bail bond producer engages an attorney on behalf of a defendant, the bail bond producer shall obtain prior written consent from the defendant.

(3) Pay a fee or rebate or give or promise anything of value to the principal or anyone in or on his behalf, including any inmate in a local jail or prison, or correctional personnel.

(4) Conduct bail bond business with any person other than the defendant, the indemnitor, and an attorney or in the case of a minor, a parent or guardian, in or on the grounds of a courthouse or jail for the purpose of executing a bail bond.

B. Any person or entity that violates the provisions of Paragraph (1), (2), or (3) of Subsection A of this Section commits a felony offense punishable by imprisonment, with or without hard labor, for no more than five years or fined an amount not to exceed ten thousand dollars, or both. In addition to any imprisonment or fine imposed, the person or entity shall forfeit and surrender to the commissioner their license to transact insurance business in this state upon finality of the conviction. Such person or entity shall be ineligible for life from obtaining a license to transact insurance business in this state.

C. Any person or entity that violates the provision of Paragraph (4) of Subsection A of this Section shall be guilty of a misdemeanor offense punishable by imprisonment in the parish jail for no more than six months or fined an amount not to exceed five thousand dollars, or both. In addition to any imprisonment or fine imposed, the person or entity shall forfeit and surrender to the commissioner their license to transact insurance business in this state upon finality of the conviction. This person or entity shall be precluded for a period of three years from obtaining any license to transact insurance business in this state.

D. The criminal provisions of this Section shall be investigated, enforced, or prosecuted only by the proper law enforcement and prosecutorial agencies.

Acts 2003, No. 223, §1, eff. June 5, 2003.

§1514.4. Surrender for nonpayment of premium

A. Before a breach of an undertaking occurs, a surety or bail bond producer may surrender a defendant, or the defendant may surrender himself, to the official to whose custody the defendant was committed at the time the bail was given. The defendant may be surrendered without a return of the premium if he changes addresses without notifying his bail bond producer or surety, conceals himself, leaves the jurisdiction of the court without the permission of his bail bond producer or surety, fails to appear in any court at any time, or if the indemnitor seeks to relieve himself of his obligation on the bond. A bail bond producer shall not surrender a client for nonpayment of a premium until thirty days after the date the bond is posted.

B. When a bail bond producer or surety surrenders a defendant, the bail bond producer or surety must file written notification and a statement of surrender indicating the lawful reason for the surrender. The statement of surrender must be attached to the surrender or recommit form with a copy provided to the defendant, committing official, and court clerk. The bail bond producer must maintain a correct copy of the statement of surrender form in the defendant's file. The statement of surrender shall read as follows:

STATEMENT OF SURRENDER

THE UNDERSIGNED SURETY/BAIL BOND PRODUCER on behalf of _____wishes to surrender/recommit the defendant and hereby authorizes _____as a licensed bail bond producer, licensed agent of the surety, or any law enforcement officer having jurisdiction to take the defendant, _____, into custody and deliver and surrender the defendant or cause the defendant to be surrendered/recommitted into the custody of. the _____ in the City/Parish of _____, State of _____.

The lawful reason for the surrender/recommit is:

_____

_____

Dated this _____day of _____, 20_____.

_____

Surety/Bail Bond Producer/Agent of Surety or Bail Bond Producer

C. Upon first violation, a bail bond producer who surrenders a client for nonpayment of a premium shall be subject to a suspension of his license for not more than six months and fined an amount not to exceed five thousand dollars. A second or any subsequent violation may be punishable by permanent revocation of the bail bond producer's license and a fine not to exceed ten thousand dollars.

Acts 2003, No. 1194, §1, eff. July 3, 2003.

CHAPTER 2. MISCELLANEOUS PROVISIONS

PART I. IN GENERAL

§1521. Donations inter vivos of life insurance policies; laws respecting form inapplicable

A. Donations inter vivos of life insurance policies, and the naming of beneficiaries therein, whether revocably or irrevocably, are not governed by the provisions of the Revised Civil Code of 1870, or any other laws of this state relative to the form of donations inter vivos.

B. This section is remedial and retrospective. All donations inter vivos of life insurance policies made on or before July 31, 1968 are valid and effective, whether or not such donations were made in the form prescribed by the Civil Code or by any other laws of this state.

Acts 1958, No. 125. Amended by Acts 1968, No. 157, §§1, 2.

§1522. REPEALED BY ACTS 1978, No. 543, §1

§1523. Advertisement by insurers

No person shall publish or print in any newspaper, magazine, periodical, circular letter, pamphlet, or in any other manner or publish by radio broadcasting in this state, any advertisement or other notice either directly or indirectly setting forth the advantages of or soliciting business for any insurer which has not been authorized to do business in Louisiana.

No person shall accept for publication or printing in any newspaper, magazine, or other periodical, or circular letter or pamphlet, or in any other manner, or for radio broadcasting in this state, any advertisement or other notice either directly or indirectly setting forth the advantages of or soliciting business for any insurer unless the advertisement or notice is accompanied by a certificate from the office of the commissioner of insurance to the effect that the insurer is authorized to do business in Louisiana.

Whoever violates this Section shall be fined not more than one thousand dollars or imprisoned for not more than one year, or both.

Acts 1958, No. 125.

§1524. Substitution of policies; charge by lender prohibited; penalty

It shall be unlawful for any person, firm or corporation engaged in financing the purchase of real or personal property, or of lending money on the security of real or personal property, or for any trustee, director, officer, agent or other employee of any such person, firm or corporation, to require, directly or indirectly, that a borrower, or any other person, in obtaining insurance coverage on the property, pay a service charge or fee of any kind to substitute the insurance policy of one insurance company for that of another.

Any violation of any of the provisions of this Section by any person, firm or corporation is declared to be a misdemeanor and is punishable by a fine of not less than one hundred dollars or more than five hundred dollars, or imprisonment for not less than sixty days or more than one year, or both fine and imprisonment, for each offense, in the discretion of the court.

Added by Acts 1958, No. 211, §§1, 2.

§1525. Ownership of domestic stock insurance company equity securities; filing of statements

Every person who is directly or indirectly the beneficial owner of more than ten per cent of any class of any equity security of a domestic stock insurance company, or who is a director or an officer of such company, shall file in the office of the commissioner of insurance, on or before the first day of July, 1966, or within ten days after he becomes such beneficial owner, director or officer, a statement, in such form as the commissioner of insurance may prescribe, of the amount of all equity securities of such company of which he is the beneficial owner, and within ten days after the close of each calendar month thereafter, if there has been a change in such ownership during such month, shall file in the office of the commissioner of insurance a statement, in such form as the commissioner of insurance may prescribe, indicating his ownership at the close of the calendar month and such changes in his ownership as have occurred during such calendar month.

Added by Acts 1966, No. 8, §1, eff. June 9, 1966 at 1:50 P.M.

§1526. Profits to inure to company; suits to recover

For the purpose of preventing the unfair use of information which may have been obtained by such beneficial owner, director or officer by reason of his relationship to such company, any profit realized by him from any purchase and sale, or any sale and purchase, of any equity security of such company within any period of less than six months, unless such security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the company, irrespective of any intention on the part of such beneficial owner, director or officer in entering into such transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding six months. Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the company, or by the owner of any security of the company in the name and in behalf of the company if the company shall fail or refuse to bring such suit within sixty days after request or shall fail to diligently prosecute the same thereafter; but no such suit shall be brought more than two years after the date such profit was realized. This Section shall not be construed to cover any transaction where such beneficial owner was not such, both at the time of the purchase and sale, or the sale and purchase, of the security involved, or any transaction or transactions which the commissioner of insurance, by rules and regulations may exempt as not comprehended within the purpose of this Section.

Added by Acts 1966, No. 8, §1, eff. June 9, 1966, at 1:50 P.M.

§1527. Unlawful sales

It shall be unlawful for any such beneficial owner, director or officer, directly or indirectly, to sell any equity security of such company if the person selling the security or his principal (1) does not own the security sold, or (2) if owning the security, does not deliver it against such sale within twenty days thereafter, or does not within five days after such sale deposit it in the mails, or other usual channels of transportation; but no person shall be deemed to have violated this Section if he proves that notwithstanding the exercise of good faith he was unable to make such delivery or deposit within such time, or that to do so would cause undue inconvenience or expense.

Added by Acts 1966, No. 8, §1, eff. June 9, 1966, at 1:50 P.M.

§1528. Sales exempt

The provisions of R.S. 22:1526 shall not apply to any purchase and sale, or sale and purchase, and the provisions of R.S. 22:1527 shall not apply to any sale, of an equity security of a domestic stock insurance company not then or theretofore held by him in an investment account, by a dealer in the ordinary course of his business and incident to the establishment or maintenance by him of a primary or secondary market (otherwise than on an exchange as defined in the Securities Exchange Act of 1934) for such security. The commissioner of insurance may, by such rules and regulations as he deems necessary or appropriate in the public interest, define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

Added by Acts 1966, No. 8, §1, eff. June 9, 1966, at 1:50 P.M.

§1529. Arbitrage transactions

The provisions of R.S. 22:1525 through 22:1527 shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules and regulations as the commissioner of insurance may adopt in order to carry out the purposes of R.S. 22:1525 through 22:1533.

Added by Acts 1966, No. 8, §1, eff. June 9, 1966, at 1:50 P.M.

§1530. "Equity security" defined

The term "equity security" when used in R.S. 22:1525 through 22:1533 means any stock or similar security; or any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right; or any other equity security of a domestic stock insurance company which the commissioner of insurance shall deem to be of a similar nature and consider necessary or appropriate, by such rules and regulations as he may prescribe in the public interest or for the protection of investors, to treat as an equity security of a domestic stock insurance company.

Added by Acts 1966, No. 8, §1, eff. June 9, 1966, at 1:50 P.M.

§1531. "Officer" defined

The term "officer" means a president, vice president, treasurer, actuary, secretary, controller, and any other person who performs for the company functions corresponding to those performed by the foregoing officers.

Added by Acts 1966, No. 8, §1, eff. June 9, 1966, at 1:50 P.M.

§1532. Securities exempt

The provisions of R.S. 22:1525 through 22:1527 shall not apply to such equity securities of a domestic stock insurance company if (a) such securities shall be registered, or shall be required to be registered, pursuant to Section 12 of the Securities Exchange Act of 1934, as amended, or if (b) such domestic stock insurance company shall not have any class of its equity securities held of record by one hundred or more persons on the last business day of the year next preceding the year in which equity securities of the company would be subject to the provisions of R.S. 22:1525 through 22:1527 except for the provisions of this subsection (b).

Added by Acts 1966, No. 8, §1, eff. June 9, 1966, at 1:50 P.M.

§1533. Rules and regulations

The Commissioner of Insurance shall have the power to make such rules and regulations as may be necessary for the execution of the functions vested in him by R.S. 22:1525 through 22:1532, and may for such purpose classify domestic stock insurance companies, securities, and other persons or matters within his jurisdiction. No provision of R.S. 22:1525 through 22:1527 imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule or regulation of the Commissioner of Insurance, notwithstanding that such rule or regulation may, after such act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

Added by Acts 1966, No. 8, §1, eff. June 9, 1966, at 1:50 P.M.

§1534. REPEALED BY ACTS 2003, No. 421, §1.

§1535. Disability insurance; contractual reductions

No policy of insurance providing disability benefits shall provide for any reduction contrary to that provided for in R.S. 23:1225(C)(2).

Acts 1995, No. 1284, §1.

PART II. FIRE INSURANCE COMPANIES

SUBPART A. FIRE INSURANCE PATROL ASSOCIATIONS

§1551. Definitions

For purposes of this Sub-part, the term "association" means a fire insurance patrol association organized under this Sub-part, except where the context clearly indicates otherwise.

Acts 1958, No. 125.

§1552. Formation of fire insurance patrol associations

Two-thirds of the fire insurance companies regularly licensed and authorized to do business in this state, may voluntarily organize, in any city of fifty thousand or more population, an association for the purpose of protecting life and property from fire in such cities. The association shall be known as the fire insurance patrol of the city in which it is organized.

Every fire insurance company regularly licensed and authorized to do business in the city in which the association has its domicile shall be a member of the association and shall have one vote.

Acts 1958, No. 125.

§1553. Officers; management

The officers of each association are its president, vice-president, secretary, and the members of its board of directors or executive committee. These officers shall be citizens of the state and residents of the city in which the association is organized.

The management of the associations organized under the provisions of this Sub-part is vested in the board of directors or executive committee.

Acts 1958, No. 125.

§1554. Certificate of approval

Immediately after organization of an association pursuant to this Sub-part, the president, the secretary, and the board of directors or executive committee thereof shall file with the commissioner of insurance a certified copy of the constitution and by-laws and a certified list of the fire insurance companies subscribing thereto. If the organization is found to conform to the provisions of this Sub-part, the commissioner of insurance shall furnish the association with a certificate of approval.

Acts 1958, No. 125.

§1555. Powers

Fire insurance patrol associations may provide and maintain a corps of men, with the proper officers and suitable apparatus and quarters, to save and preserve life and property at and after a fire. The officers and men of the associations may enter any building on fire or which, in their judgment, is immediately exposed to or in danger of taking fire from other burning buildings to protect and save property therein and to remove such property or any part thereof at or immediately after a fire. However, nothing in this Sub-part shall be so construed as to lessen in any way the authority of the fire department of the city in which the association has its domicile or to warrant or justify any interference with such department in the performance of its duties.

Acts 1958, No. 125.

§1556. No charges or discrimination by associations

No charge of any kind shall be imposed, for services rendered by an association in the public interest and, in the efforts to protect and save life and property at and during any fire, no discrimination shall be made between property which is insured and that which is uninsured.

Acts 1958, No. 125.

§1557. Right of way enroute to fire

The officers and men of a fire insurance patrol association, with all of their apparatus, have the same right of way enroute to a fire as the fire department of the city and any violation of the street rights of associations shall be punished by the city in the same manner as a violation of the rights of the fire departments.

Acts 1958, No. 125.

§1558. Annual statements by fire insurers, assessments for expenses of associations

An association may require a statement to be furnished it annually by all fire insurance companies, associations, or underwriters writing fire insurance, regularly licensed and authorized to do business in the state, showing the gross amount of premiums received for insuring movable and immovable property against loss by fire in the city in which the association has its domicile, for the twelve months next preceding December 31 of each year. Only return premiums paid during the twelve months shall be deducted from the gross premiums. This statement shall be made on forms furnished by the association and shall be sworn to by the president, secretary, general agent, or manager of the fire insurance company, association, or underwriter. It shall be filed with the secretary of the fire insurance patrol association within sixty days after the close of the year which it covers.

To pay its expense, any association, through its board of directors or executive committee, may levy an assessment on all fire insurance companies, associations, or underwriters regularly licensed and authorized to do business in this state, in proportion to the several amounts of gross premiums received by each, less return premiums paid. This assessment shall be based on the estimated expenses for the current year, together with liabilities due, and shall never exceed two per cent of the gross amount of premiums received, less return premiums paid. The assessment shall be paid at the time of the filing of the statement provided for in this Section.

Acts 1958, No. 125.

§1559. Delinquent members of associations; demand for statements and collection of assessments by commissioner of insurance

The secretaries of the various associations shall report to the commissioner of insurance all fire insurance companies, associations, or underwriters failing to make statements of the amount of premiums received as provided in R.S. 22:1558 or failing to pay the assessments levied pursuant to that Section, with a statement of the amount due by each. The commissioner of insurance shall make demand on the delinquent companies for the statements, and shall collect the amounts due by such delinquent companies. He shall pay over the sums so collected to the association. For this service the commissioner of insurance shall deduct a fee of five per cent of the amount collected and paid over.

Acts 1958, No. 125.

§1560. Revocation of license of delinquent members; reinstatement

The commissioner of insurance shall revoke the license of any fire insurance company, association, or underwriter who fails to comply with his demands as provided in R.S. 22:1559 after fifteen days' written notice to do so and during such interval of fifteen days, the fire insurance company, association, or underwriter may urge any valid or legal reason why its license should not be revoked. The commissioner of insurance shall, at the expiration of the fifteen days, determine whether or not the licenses shall be revoked, and, if he decides in the affirmative, the revocation shall be self-operative. Reinstatements may be made at the discretion of the commissioner of insurance, provided the demands authorized to be made by him in R.S. 22:1559 have first been complied with.

Acts 1958, No. 125.

SUBPART B. FOREIGN OR ALIEN FIRE INSURANCE COMPANIES

§1580. Definitions

For the purposes of this Subpart, the terms as used herein shall have the following meanings:

(1) "Active volunteer fire department" means a voluntary organized fire company which possesses, in serviceable condition for fire duty, apparatus and equipment having a total value of five thousand dollars or more.

(2) "A regularly paid fire department of an incorporated municipality or a fire and waterworks district in any unincorporated municipality" means a regularly paid fire department of such municipality or district which possesses, in serviceable condition for fire duty, apparatus and equipment having a total value of five thousand dollars or more.

Added by Acts 1976, No. 218, §1, eff. Jan. 1, 1977.

§1581. Annual report of premiums received; verified statements by municipality, district, or volunteer fire department

Every foreign or alien insurer, other than life, desiring to engage in or carry on business in this state shall return to the state treasurer a just and true account, verified by oath of the proper officer, of all premiums received from business in this state which insures property of any nature or description against loss or damage by fire, during the year ending December 31 of each year. Any incorporated municipality or any fire or waterworks district in any unincorporated municipality as may be established by ordinance of the governing authority of any parish of this state having or that may have a regularly paid fire department, as defined in R.S. 22:1580, under the control of the mayor or council or other governing authority, and on any property of an area actually served by an active volunteer fire department, as defined in R.S. 22:1580, shall be eligible to participate upon certification. Such returns must be made by the said companies within sixty days after December 31 of each year, provided that the mayor and council or regularly constituted authority of the incorporated municipality or the governing authority of the fire and waterworks district in any unincorporated municipality or the fire chief of the active volunteer fire department, as defined in R.S. 22:1580, shall file a verified statement as required by the governing authority of the parish on or before October 1 of each year. Provided that whenever any incorporated municipality or fire or waterworks district of any unincorporated municipality or active volunteer fire department is qualified as required by this Section for the first time, the treasurer of the governing authority of the parish shall have qualified or certified such body as being eligible to receive the tax. This statement must show that the incorporated municipality or the fire or waterworks district in any unincorporated municipality has a regularly paid fire department, as defined in R.S. 22:1580, and that it possesses fire duty apparatus and equipment in serviceable condition having a total value of five thousand dollars or more; and in the case of a volunteer fire department this statement must show that such volunteer fire department is an active volunteer fire department as defined in R.S. 22:1580, and that it possesses fire duty apparatus and equipment in serviceable condition having a total value of five thousand dollars or more. If any such incorporated municipality or any fire and waterworks district in any unincorporated municipality or active volunteer fire department fails to file a certified statement by the time herein prescribed, the verified statement may be filed at any time subsequent within one year from the time established herein, provided a like statement is filed with the Property Insurance Association of Louisiana. Provided, the statement to be furnished by an active volunteer fire department to the treasurer of the governing authority of the parish on or before October 1 of each year or the verified statement filed within one year subsequent thereto shall contain a map or survey of the area actually served by the active volunteer fire department prepared by a registered surveyor or licensed civil engineer. If an active volunteer fire department is located within an incorporated municipality or fire and waterworks district only the incorporated municipality or the fire and waterworks district shall file a verified statement as provided for herein.

Acts 1958, No. 125. Amended by Acts 1958, No. 417, §1; Acts 1976, No. 218, §2, eff. Jan. 1, 1977.

§1582. Accounts to be kept

Every such company shall keep accurate accounts of all fire insurance business done by them. Each such insurer shall submit to the state treasurer a verified return for insurance premiums received by such insurer for insurance of property of whatever nature and kind from loss or damage by fire in the state of Louisiana during the year ending December 31 of each year.

Acts 1958, No. 125. Amended by Acts 1976, No. 218, §2, eff. Jan. 1, 1977.

§1583. Tax on premiums

A foreign and alien insurer, other than a life insurer, shall, within sixty days after December 31 of each year, pay to the commissioner of insurance a sum equal to two percent of the amount of premiums received from any business which insures property of any nature or description against loss or damage by fire shown by the insurer in the return required by R.S. 22:1581. If, however, the verified statement required of the insurer in R.S. 22:1581 is filed subsequent to the time specified in that Section, the tax fixed in this Section shall be paid within ninety days after the filing.

Acts 1958, No. 125. Amended by Acts 1958, No. 418, §1. Acts 1984, No. 229, §1.

§1584. Investigation and collection by commissioner of insurance

If a company fails to keep the accurate accounts required in R.S. 22:1582 or if the returns required in R.S. 22:1581 are apparently fraudulent or dishonest, the commissioner of insurance shall investigate the returns and collect the amount he finds to be due. Verification shall be made from the Louisiana exhibit of premiums by lines of business reflecting statewide totals as contained in the annual financial statement of the National Association of Insurance Commissioners filed with the commissioner of insurance.

Acts 1958, No. 125. Amended by Acts 1976, No. 218, §2, eff. Jan. 1, 1977.

§1585. Disposition of tax money

A. Monies collected under the provision of this Subpart, after being first credited to the Bond Security and Redemption Fund in accordance with Article VII, Section 9 (B) of the Constitution of Louisiana, shall be credited to a special fund hereby established in the state treasury and known as the "Two Percent Fire Insurance Fund" hereinafter the "fund". Monies in the fund shall be available in amounts appropriated annually by the legislature for the following purposes in the following order of priority:

(1) For the state fire marshal, an amount necessary to satisfy the requirements of R.S. 40:1593, relative to the purchase of group insurance for volunteer firefighters.

(2) For the Fire and Emergency Training Institute at Louisiana State University at Baton Rouge for allocation to the Pine Country Education Center in the parish of Webster, the sum of seventy thousand dollars per year, which shall be transferred without imposition of administrative fee or cost, to be used to develop and operate a firefighter training center operated in accordance with the standards and requirements of the Fire and Emergency Training Institute at Louisiana State University at Baton Rouge.

(3) For the Fire and Emergency Training Institute at Louisiana State University at Baton Rouge, the sum of seventy thousand dollars per year for support of the firefighter training program.

(4) For distribution to each parish governing authority in accordance with rules and regulations established by the state treasurer based upon the formula provided for herein:

(a) Except in Orleans Parish, the state treasurer shall pay over to the treasurer of each governing authority of the parish described in R.S. 22:1581 the full amount of money due as determined by the state treasurer. These funds shall be allocated, distributed, and paid to each parish on the basis of a determination of the established population category of each parish as shown by the latest federal census or as determined by the Division of Business and Economic Research of Louisiana Tech University under the latest federal-state cooperative program for local population estimates. Such determination shall be submitted by the Division of Business and Economic Research of Louisiana Tech University to the state treasurer annually not later than January fifteenth of each calendar year. Any parish governing authority which is aggrieved by such determination may file a petition for administrative review with the state treasurer not later than March fifteenth of each calendar year. The determination so submitted shall have no effect on the distribution for the fiscal year in which it is made, but shall be utilized for purposes of this Subpart for distribution during the next ensuing fiscal year as follows:

(i) Those regularly paid fire departments of an incorporated municipality or fire and waterworks district in any unincorporated municipality or active volunteer fire departments having a population within its geographical area of one to two thousand five hundred shall receive seven hundred fifty dollars per annum.

(ii) Those regularly paid fire departments of an incorporated municipality or fire and waterworks district in any unincorporated municipality or active volunteer fire departments having a population of two thousand five hundred one to five thousand shall receive one thousand dollars per annum.

(iii) Those regularly paid fire departments of an incorporated municipality or fire and waterworks district in any unincorporated municipality or active volunteer fire departments having a population of five thousand one or more shall receive one thousand two hundred fifty dollars per annum.

(b) Additional funds shall be distributed to each parish based on the following population formula:

(i) Where the population is twenty-four thousand or less, the parish shall receive thirty-four cents for each inhabitant.

(ii) Where the population is twenty-four thousand one to fifty-five thousand inclusive, the parish shall receive thirty-seven cents per inhabitant.

(iii) Where the population is fifty-five thousand one to one hundred thousand inclusive, the parish shall receive forty cents per inhabitant.

(iv) Where the population is one hundred thousand one to two hundred fifty thousand inclusive, the parish shall receive forty-four cents per inhabitant.

(v) Where the population is two hundred fifty thousand one to four hundred twenty-five thousand inclusive, the parish shall receive forty-seven cents per inhabitant.

(vi) Where the population is over four hundred twenty-five thousand, the parish shall receive fifty cents per inhabitant.

(c) Any balance which remains after making the distributions required in Subparagraph (b) of this Paragraph shall be allocated on an equal per capita basis until all of the available funds are utilized.

(d) If the total amount of monies available for distribution pursuant to Subparagraph (b) of this Paragraph is less than the one hundred percent required to fully implement such formula, the amount distributed shall be prorated equally among the formula categories by the state treasurer prior to distribution to each parish governing authority.

B. These funds shall be allocated, distributed, and paid by each parish governing authority to each regularly constituted fire department of the municipality or district, or active volunteer fire department certified by the parish governing authority, based on the population within the area serviced by said regularly constituted fire department of the municipality or district, or active volunteer fire department. In order to determine the amount of the funds which shall be paid to each fire department, district, or municipality, from the parish governing authority, the following formula shall be applied:

(1) Total population serviced by all certified fire units in the parish divided into the total monies received by the parish from this tax equals the per capita available for distribution to certified local fire units.

(2) Total population serviced by each certified local fire unit in the parish multiplied by the per capita available as determined by Paragraph (1) of this Subsection equals the funds due each certified local fire unit in the parish.

C. The distribution of the proceeds from the premium tax shall in no way be considered as a basis for reduction of any additional parish funds currently remitted to local fire units for the purpose of fire protection.

D.(1) All money received under the provisions of this Subpart by the treasurer of the governing authority of the parish shall, within thirty days from the time it is received, be paid over by the treasurer to the fiscal representative of the regularly constituted fire department of the municipality or district or active volunteer fire department, as the case may be. If any of said funds are not so distributed either by mutual consent or without consent of the regularly paid fire department of the municipality or district or active volunteer fire department certified by the parish governing authority, such funds shall be invested in an interest-bearing account and any accrued interest on the investment of funds shall be credited and distributed per capita to the regularly paid fire department of the municipality or district or active volunteer fire department, as provided by R.S. 22:1585.

(2) Such money shall be used only for the purpose of rendering more efficient and efficacious the regularly paid fire department of the municipality or district or active volunteer fire department, as the case may be, in such manner as the governing body shall direct.

E. In Orleans Parish the state treasurer shall pay over to the secretary-treasurer of the board of trustees of the Firefighter's Pension and Relief Fund of the city of New Orleans all monies due under the provisions of this Subpart collected pursuant to R.S. 22:1583. Such money shall be used only for the purpose of rendering more efficient and efficacious the pension system of the fire department of the city of New Orleans in such manner as the governing body of said pension fund shall direct as provided by law.

NOTE: Subsection F REPEALED BY Acts 2001, No. 189, §3, eff. July 1, 2002.

F. The Volunteer Firefighter Insurance Premium Fund, hereafter referred to as the "fund", is hereby created as a special fund in the state treasury.

Acts 1958, No. 125. Amended by Acts 1969, No. 119, §1; Acts 1976, No. 218, §2, eff. Jan. 1, 1977; Acts 1989, No. 795, §1, eff. July 1, 1989; Acts 1990, No. 759, §1; Acts 1991, No. 263, §1; Acts 1995, No. 641, §1; Acts 2001, No. 189, §1, eff. May 31, 2001, No. 189, §3, July 1, 2002.

§1586. Penalties

Any foreign or alien insurer, other than life, which violates any provision of this Sub-part shall, for each offense, be fined five hundred dollars.

Acts 1958, No. 125. Amended by Acts 1958, No. 419, §1.

§1587. Fire insurance associations not incorporated under laws of Louisiana

No fire insurance association not incorporated under the laws of this state shall carry on any fire insurance business in this state, save and except upon compliance with the conditions imposed in R.S. 22:1580 through 22:1586 as well as all other conditions which may be now or hereafter imposed by law.

Acts 1958, No. 125. Amended by Acts 1976, No. 218, §2, eff. Jan. 1, 1977.

PART III. AMBULANCE POLICIES

§1621. REPEALED BY ACTS 1999, No. 480, §1.
§1622. REPEALED BY ACTS 1999, No. 480, §1.
§1623. REPEALED BY ACTS 1999, No. 480, §1.
§1624. REPEALED BY ACTS 1999, No. 480, §1.
§1625. REPEALED BY ACTS 1999, No. 480, §1.
§1626. REPEALED BY ACTS 1999, No. 480, §1.
§1627. REPEALED BY ACTS 1999, No. 480, §1.

PART IV. TAX EXEMPTIONS

§1661. Certain non-profit mutual associations declared charitable institutions

Any domestic non-profit mutual association, the net earnings of which do not inure to the benefit of any individual, which is engaged exclusively in the business of furnishing hospital service, medical, or surgical benefits, so that such services or benefits are furnished to those of the public who become subscribers of the plan, and at least a majority of whose directors or managing officers are administrators, trustees, or members of the clinical staffs or advisory boards of non-profit hospitals having contracts with the association, or are licensed doctors of medicine who are members of their parish medical society and of the Louisiana State Medical Society is declared to be a charitable and beneficial institution. As such, its receipts, surplus and reserves are exempt from all forms of taxation by the state or any of its political sub-divisions, except taxes on the real estate and the office equipment owned by the association and the license provided for in R.S. 22:1662. This exemption from taxation applies to any form of taxation, licenses, fees, or assessments which has heretofore or which may hereafter become due the state or any of its political subdivisions.

Acts 1958, No. 125.

§1662. License fee; filing of charter and by-laws and annual affidavit; certificate

Any association of the type described in R.S. 22:1661 which desires to take advantage of the tax exemption granted therein shall pay an annual license fee of two hundred and fifty dollars to the commissioner of insurance and shall furnish him with a certified copy of its charter and by-laws and, annually, on or before the first day of March, an affidavit signed by its president and secretary, showing the names and addresses of all of its directors or managing officers and the non-profit hospitals or medical societies which a majority of the directors represent. Upon payment of the license fee by the association and approval of the affidavit by the commissioner of insurance, the latter official shall furnish the association with a certificate under seal of his office, certifying that the association is exempt from all taxes, licenses, fees, or assessments due to the state or to any of its political subdivisions, except the payment of the annual license of two hundred and fifty dollars.

Acts 1958, No. 125.

§1663. Policy provisions

No insurer which takes advantage of the provisions of R.S. 22:1661 shall provide in any of its policies that the insured, or his dependents, covered under any policy issued by it shall be hospitalized in any particular kind or type of hospital or that any hospital which has furnished the hospitalization service or other benefits must be a member of or meet the requirements of any hospital or medical association or society. However, the policy may require that the hospital or other institution in which the benefits are furnished shall maintain adequate records of the diagnosis and treatment of the insured.

Acts 1958, No. 125.

PART V. COUNTERSIGNATURE BY RESIDENT AGENT

§1701. REPEALED BY ACTS 1999, No. 882, §2, eff. July 2, 1999.
§1702. REPEALED BY ACTS 1999, No. 882, §2, eff. July 2, 1999.
§1703. REPEALED BY ACTS 1999, No. 882, §2, eff. July 2, 1999.

PART VI. LONG-TERM CARE INSURANCE ACT

§1731. Purpose

The purposes of this Part are: to promote the public interest; to promote the availability of long-term care insurance policies, or certificate if a group; to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices; to establish standards for long-term care insurance; to facilitate public understanding and comparison of long-term care insurance policies; and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

Acts 1989, No. 448, §1, eff. Sept. 1, 1989; Acts 1997, No. 308, §1, eff. June 17, 1997.

§1732. Scope

The requirements of this Part shall apply to policies delivered or issued for delivery in this state on or after September 1, 1989. Renewal policies shall comply with this Part, as amended. This Part is not intended to supersede the obligations of entities subject to this Part to comply with the substance of other applicable insurance laws insofar as they do not conflict with this Part, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance.

Acts 1989, No. 448, §1, eff. Sept. 1, 1989; Acts 1993, No. 658, §1, eff. Jan. 1, 1994; Acts 2004, No. 780, §1, eff. January 1, 2005.

§1733. Short title

This Part may be known and cited as the "Long-Term Care Insurance Act".

Acts 1989, No. 448, §1, eff. Sept. 1, 1989.

§1734. Definitions

Unless the context requires otherwise, the following definitions in this Section shall apply for purposes of this Part:

(1) "Applicant" means:

(a) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits, and

(b) In the case of a group long-term care insurance policy, the proposed certificate holder.

(2) "Certificate" means any certificate issued under a group long-term care insurance policy, which certificate has been delivered or issued for delivery in this state whether or not a master policy has been issued and approved in another state.

(3) "Commissioner" means the Louisiana commissioner of insurance.

(4) "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:

(a) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or

(b) Any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if such association:

(i) Is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and

(ii) Has been maintained in good faith for purposes other than obtaining insurance; or

(c)(i) An association or a trust or the trustee of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the commissioner that the association or associations have at the outset a minimum of one hundred persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws which provide that:

(aa) The association or associations hold regular meetings not less than annually to further purposes of the members;

(bb) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(cc) The members have voting privileges and representation on the governing board and committees.

(ii) Thirty days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

(d) A group other than as described in Subparagraphs (4)(a), (4)(b), and (4)(c) of this Section, subject to a finding by the commissioner that:

(i) The issuance of the group policy is not contrary to the best interest of the public;

(ii) The issuance of the group policy would result in economies of acquisition or administration; and

(iii) The benefits are reasonable in relation to the premiums charged.

(5)(a) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital.

(b) Such term includes group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance. The term shall include a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations, or any similar organization to the extent they are otherwise authorized to issue life or health insurance.

(c) Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(d) With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

(e) Notwithstanding any other provision of law to the contrary, any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions of this Part.

(6) "Policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization; or any similar organization.

(7)(a) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:

(i) The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this Item by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(ii) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this Item do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this Item by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(iii) The contract is guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

(iv) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in Item (v) of this Subparagraph.

(v) All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract.

(vi) The contract meets the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code of 1986, as amended.

(b) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Sections 7702B(b) and (e) of the Internal Revenue Code of 1986, as amended.

Acts 1989, No. 448, §1, eff. Sept. 1, 1989; Acts 1993, No. 658, §1, eff. Jan. 1, 1994; Acts 1997, No. 308, §1, eff. June 17, 1997; Acts 2004, No. 780, §1, eff. January 1, 2005.

§1735. Extraterritorial jurisdiction; group long-term care insurance

No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in R.S. 22:1734(4)(d), unless this state has made a determination that such requirements have been met.

Acts 1989, No. 448, §1, eff. Sept. 1, 1989; Acts 2004, No. 780, §1, eff. January 1, 2005.

§1736. Disclosure and performance standards for long-term care insurance

A. The commissioner may adopt rules and regulations that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms.

B. No long-term care insurance policy may:

(1) Be cancelled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder.

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

(3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(4) Be marketed or sold as a federally tax-exempt policy, unless such policy contains provisions for automatic amendment to conform with mandatory federal requirements necessary to maintain such tax-exempt status and provides notice thereof approved by the commissioner.

C. (1) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in R.S. 22:1734(4)(a) shall use a definition of "preexisting condition" which is more restrictive than the following: "preexisting condition" means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services, within six months preceding the effective date of coverage of an insured person.

(2) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in R.S. 22:1734(4)(a) may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.

(3) The commissioner may extend the limitation periods set forth in Paragraphs (C)(1) and (2) of this Section as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in R.S. 22:1736(C)(2) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in R.S. 22:1736(C)(2).

D. Prior hospitalization/institutionalization. (1) No long-term care insurance policy may be delivered or issued for delivery in this state if such policy does any of the following:

(a) Conditions eligibility for any benefits on a prior hospitalization requirement.

(b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care.

(c) Conditions eligibility for any benefits other than a waiver of the premium, post-confinement, post-acute care, or recuperative benefits on a prior institutionalization requirement.

(2)(a) A long-term care insurance policy containing post-confinement, post-acute care, or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits", such limitations or conditions, including any required number of days of confinement.

(b) A long-term care insurance policy or rider which conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty days.

E. The commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

F. Right to return-free look. Long-term care insurance applicants shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. This Subsection shall also apply to denials of applications, and any refund shall be made within thirty days of the return or denial.

G. (1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient of the document and its purpose.

(a) The commissioner shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of an outline of coverage.

(b) In the case of producer solicitations, a producer shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(c) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(2) The outline of coverage shall include each of the following:

(a) A description of the principal benefits and coverage provided in the policy.

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy.

(c) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described.

(d) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions.

(e) A description of the terms under which the policy or certificate may be returned and premium refunded.

(f) A brief description of the relationship of cost of care and benefits.

(g) A statement that discloses to the policyholder or certificateholder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under 7702B(b) of the Internal Revenue Code of 1986, as amended.

H. If an applicant for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty days after the date of approval.

I. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct-response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make delivery no later than at the time of policy delivery. In addition to complying with applicable requirements, the summary shall also include:

(1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits.

(2) An illustration of the amount of benefits, the length of the benefit, and the guaranteed lifetime benefits, if any, for each covered person.

(3) Any exclusions, reductions, and limitations on benefits of long-term care.

(4) A statement that any long-term care inflation protection option required by §1919 of Regulation 46 is not available under this policy.

(5) If applicable to the policy type, the summary shall also include each of the following:

(a) A disclosure of the effects of exercising other rights under the policy.

(b) A disclosure of guarantees related to long-term care costs of insurance charges.

(c) Current and projected maximum lifetime benefits.

(6) The provisions of the policy summary listed above may be incorporated into a basic illustration required to be delivered in accordance with §3309 and §3311 of Regulation 55.

J. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include the following:

(1) Any long-term care benefits paid out during the month.

(2) An explanation of any changes in the policy, including death benefits or cash values, due to the long-term care benefits being paid out.

(3) The amount of long-term care benefits existing or remaining.

K. If a claim under a long-term care insurance contract is denied, the issuer shall within sixty days from the date of a written request by the policyholder or certificateholder, or a representative thereof do the following:

(1) Provide a written explanation of the reasons for the denial.

(2) Make available all information directly related to the denial.

L. No policy may be advertised, marketed, or offered as long-term care or nursing home insurance unless it complies with the provisions of this Part.

Acts 1989, No. 448, §1, eff. Sept. 1, 1989; Acts 1993, No. 658, §1, eff. Jan. 1, 1994; Acts 1997, No. 308, §1, eff. June 17, 1997; Acts 2004, No. 780, §1, eff. January 1, 2005.

§1737. Incontestability period

A. For a policy or certificate that has been in force for less than six months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance of the coverage.

B. For a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

C. After a policy or certificate has been in force for two years, it is not contestable upon the grounds of material misrepresentation alone; such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented material facts relating to the insured's health.

D.(1) No long-term care insurance policy or certificate may be field issued based on medical or health status.

(2) For purposes of this Section, "field issued" means a policy or certificate issued by a producer or a third-party administrator pursuant to the underwriting authority granted to the producer or third-party administrator by an insurer.

E. If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

F. In the event of the death of the insured, this Section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by R.S. 22:170. In all other situations, this Section shall apply to life insurance policies that accelerate benefits for long-term care.

Acts 1989, No. 448, §1, eff. Sept. 1, 1989; Acts 2004, No. 780, §1, eff. January 1, 2005.

§1738. Nonforfeiture benefits

A. Except as provided in Subsection B of this Section, a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificateholder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificateholder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

B. When a group long-term care insurance policy is issued, the offer required in Subsection A of this Section shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in R.S. 22:1734(4), other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificateholder.

C. The commissioner shall promulgate regulations specifying the type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in Subsection A of this Section.

Added by Acts 2004, No. 780, §1, eff. January 1, 2005.

§1739. Authority to promulgate regulations

The commissioner shall issue reasonable regulations to promote premium adequacy and to protect the policyholder in the event of substantial rate increases and to establish minimum standards for marketing practices, producer compensation, producer testing, penalties, and reporting practices for long-term care insurance.

Added by Acts 2004, No. 780, §1, eff. January 1, 2005.

§1740. Administrative procedure

Regulations adopted pursuant to this Part shall be adopted in accordance with the provisions of the Administrative Procedure Act.

Added by Acts 2004, No. 780, §1, eff. January 1, 2005.

§1741. Penalties

In addition to any other penalties provided by law, any insurer and any producer found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars, whichever is greater.

Added by Acts 2004, No. 780, §1, eff. January 1, 2005.

PART VII. AUTOMOBILE SERVICE CLUBS

§1751. Title

This part shall be known and may be cited as the Automobile Services Act.

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973.

§1752. Definitions

As used in this Part:

(1) "Automobile club" shall mean any person who in consideration of dues, assessments, or periodic payments of money, promises its members or subscribers to assist them in matters relating to travel and the operation, use and maintenance of an automobile in the supply of features or services which may include, by way of illustration and not by way of limitation:

(a) Such service as community traffic safety services, travel and touring services, theft or reward service, map service, towing service, emergency road service, bail bond service and legal fee reimbursement service in the defense of traffic offenses, none of which enumerated features or services, if provided by the automobile club itself, shall be subject to the insurance laws of this state:

(b) The purchase of accidental injury and death benefits insurance coverage issued, as provided by applicable statutes, by an insurance company authorized to do business in Louisiana; and

(c) Such other features or services not deemed by the commissioner to constitute the business of insurance.

(2) "Commissioner" means the commissioner of insurance of the State of Louisiana.

(3) "Club agent" is a person other than the automobile club itself, who acts or aids in any manner in the solicitation, delivery, or negotiation of any service contract, or of the renewal or continuance thereof. This, however, shall not include any person performing only work of a clerical nature in the office of the automobile club.

(4) "Service contract" means an agreement whereby an automobile club, for a consideration, promises to render, furnish, procure or reimburse club members specified services.

(5) "Person" means any individual person, firm, company, corporation, partnership or association which conducts an automobile club service business in this state.

(6) "Insurance service" means the selling or making available, of individual or group insurance policies or certificates other than service contracts as a result of membership in or affiliation with an automobile club; such policies, if sold or made available, shall be issued only by an insurance company duly authorized to do business in Louisiana. The solicitation and sale of such insurance service in the form of individual or group accidental injury and death insurance policies or certificates by a club agent shall not constitute the solicitation and sale of insurance, and the club agent shall not be required to be a licensed insurance agent in connection with the solicitation and sale of a membership contract which includes such insurance service.

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973. Amended by Acts 1975, No. 260, §1.

§1753. Deposit required; condition

No automobile club shall render or agree to render service without first depositing and thereafter continuously maintaining security in one of the following forms with the commissioner:

(1) The sum of twenty-five thousand dollars in cash or twenty-five thousand dollars surety bonds by a surety company authorized to do business in Louisiana, or twenty-five thousand dollars in securities of a type approved by the commissioner and qualified for a legal investment by an insurance company authorized to do business in Louisiana.

(2) If any security deposited with the commissioner shall become impaired and shall not be restored within thirty days after written demand by the commissioner, the commissioner shall revoke the certificate of authority of the automobile club, or in the alternative the commissioner may require such additional security deposit as in his discretion he shall deem necessary to restore adequate securities for the automobile club deposit.

(3) The security required to be filed by this act shall be for the protection, use and benefit of any club member and shall be subject to the following conditions, and, if a surety bond, shall be so expressly conditioned that:

(a) The club will faithfully furnish and render to the club members any and all of the automobile club services sold or offered for sale by it; and

(b) The club will pay any fines, fees, or penalties imposed upon it pursuant to the provisions of this part.

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973.

§1754. Surety bond; suit

If a surety bond is filed, any applicant defrauded or injured by any wrongful act, misrepresentation or failure on the part of the automobile club with respect to the selling or rendering of any of its services, may bring suit on such bond in his own name; but the aggregate liability of the surety for all such suits, shall, in no event, exceed the sum of such bond.

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973.

§1755. Cash or securities; conditions

A deposit of cash or securities, in lieu of the surety bond, shall be subject to the conditions applying to the bond and to execution on judgments against the club.

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973.

§1756. Name; deceptively similar

The name of the automobile club shall be submitted to the commissioner for approval before the commencement of business under the provisions of this part. The commissioner shall reject any name so submitted when the proposed name would interfere with the transaction of an automobile club already doing business in this state, or is deceptively similar to that of any other automobile club or other corporation licensed or qualified to do business in this state.

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973.

§1757. Certificate of authority; requirements

A. No person shall render or agree to render automobile club service in this state without first obtaining from the commissioner a certificate of authority.

B. An application for an original certificate of authority as an automobile club shall be made to the commissioner in such form and detail as the commissioner shall prescribe, shall be executed under oath by the club president or other principal officer, and shall have attached thereto:

(1) A copy of the club's charter as amended, certified, if a foreign company, by the proper public officer of the state or county of domicile, and its bylaws if any;

(2) A verified statement showing all assets and liabilities and the number of members in all states or territories in which it operates as of December 31 of the preceding year;

(3) The location of the office of the automobile club in this state, if any, and the name of its registered agent in this state;

(4) The irrevocable written consent of the automobile club that actions may be commenced against it in the proper court in any parish in the state in which the cause of action may arise or in which the plaintiff may reside by the service of process on the named resident agent mailed to him at his office, and that it has appointed the commissioner as its attorney to receive service of legal process in the event such service cannot be made upon the registered agent;

(5) A copy of each form of service agreement, contract, and service brochure it proposes to use in this state;

(6) If a foreign company, a certificate, from the proper public official of its state or county of domicile, showing that it is duly organized and is authorized to transact the type of automobile club service which it proposes to transact in Louisiana;

(7) Other documents or stipulations as the commissioner may reasonably require to evidence compliance with the provisions of the laws of this state;

(8) A certificate, issued by the secretary of state, that it has qualified to do business as a corporation in this state;

(9) Evidence that it has complied with the deposit requirement set forth in this Part;

(10) Any other relevant document that is requested by the commissioner.

C. The application shall be accompanied by a fee of three hundred dollars payable to the commissioner.

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973. Acts 1983, 1st Ex. Sess., No. 23, §1.

§1758. Certificate of authority; issuance; renewal

A. The commissioner shall issue a certificate of authority to an automobile club upon compliance with R.S. 22:1757 and upon receipt of proof satisfactory to the commissioner that the owners, members of the board of directors, officers and managers are of good reputation.

B. The certificate shall continue in force as long as the automobile club is entitled thereto under this Part and until suspended or revoked by the commissioner, or terminated at the request of the automobile club subject, however, to renewal of the certificate by the automobile club each year by:

(1) Payment, prior to March 1 of each year following that in which its original certificate is filed, of a fee of two hundred dollars;

(2) Due filing by the automobile club of its verified statement showing a list of all assets and liabilities as of the preceding December 31 to be filed by March 1 of each year.

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973. Acts 1983, 1st Ex. Sess., No. 23, §1.

§1759. Certificate of authority; expiration

Certificates of authority shall expire as of midnight March 31st unless renewed. The commissioner shall promptly notify the automobile club of the occurrence of any failure resulting in a pending expiration of its certificate of authority.

The commissioner may, in his discretion upon the automobile club's request, made within three months after expiration, reinstate and renew a certificate of authority which the automobile club had inadvertently permitted to expire, after the automobile club has fully cured all its failures which resulted in expiration, and upon payment by the automobile club of a fee for reinstatement of one hundred fifty dollars. Otherwise, the automobile club shall be granted another certificate of authority only after filing application therefor and meeting all other requirements as for an original certificate of authority in this state.

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973.

§1760. Certificate of authority; refusal; suspension; revocation; fines

A. A certificate of authority may be refused, or a certificate duly issued may be suspended or revoked, or the renewal thereof refused, or in lieu of suspension or revocation of a certificate duly issued, a fine not to exceed five hundred dollars may be levied by the commissioner if, after notice and hearings as hereafter provided, he finds that the applicant for, or holder of such certificate:

(1) Has violated any provision of this part; or

(2) It is found by the commissioner to be in such financial condition that its further transaction of automobile club service in this state would be hazardous to its members and the automobile club service buying public in this state or that it is insolvent; or

(3) It refuses to remove or discharge, or terminate its relationship with a director or officer who has been convicted of any crime involving fraud, dishonesty, or lack of moral turpitude; or

(4) It customarily or in the regular course of business compels claimants under its service contract either to accept less than the amount due them or fewer services, or to bring suit against it to secure full payment of the amount of all services due; or

(5) It conducts its business outside this state in such a manner as unjustly to discriminate against or prejudice the interest of the people of this state; or

(6) It is affiliated with and is under the same general management or interlocking directorate or ownership as another automobile club which transacts business in this state which does not have a certificate of authority therefor; or

(7) It exceeds its charter powers of its certificate of authority; or

(8) It refuses to be examined, or if its directors, managing officers, employees or representatives refuse to submit to examination by the commissioner when required by him, or refuse to perform any legal obligation relative to the examination, the time and place of the examination to be specified by the commissioner; or

(9) It maintains, through its employees, a policy of misrepresenting to the public its service contracts.

B. Before any certificate shall be refused or suspended or revoked, or the renewal thereof refused hereunder, or any fine levied hereunder, the commissioner shall give notice of his intention so to do, by registered mail, to the applicant for or holder of such certificate any applicant or holder of a certificate aggrieved may apply and shall be entitled to a hearing to be called and held in accordance with the provisions of Part XXIX of Title 22 Revised Statutes of 1950. The commissioner is authorized to withhold any fine imposed under this section, and R.S. 22:1766.

C. No certificate holder whose certificate has been revoked hereunder shall be entitled to file another application for a certificate within one year from the effective date of such revocation, or if judicial review of such revocation is sought, within one year from the date of final court order affirming such revocation. Any application, when filed, may be refused by the commissioner unless the applicant shows good cause why the revocation of his certificate shall not be deemed a bar to the issuance of a new certificate.

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973.

§1761. Service contracts required; provisions

No service contract shall be executed, issued or delivered in this state until the form thereof has been approved in writing by the commissioner.

The service contract may be in the form of a written agreement between the automobile club and the member or it may consist of a completed application, a membership card and a written description of services to be rendered by the automobile club.

No service contract shall be executed, issued or delivered in this state unless it contains the following:

(1) The exact corporate or other name of the club.

(2) The location of its home office and its usual place of business in this state, if any, giving street number and city;

(3) A provision that the contract may be cancelled at any time by given written notice thereof by either the club or the holder, and that the holder will, if the dues or membership fee has been paid, thereupon be entitled to a refund of the unused portion of the consideration paid for such contract, calculated on a prorata basis over the period of the contract, without any deductions, provided that the automobile club may make a reasonable minimum charge;

(4) A provision plainly specifying the services promised, that the holder will not be required to pay any sum, in addition to the amount specified in the contract for any services thus specified, the territory wherein such services are to be rendered, the effective date of the contract and the first renewal date;

(5) A statement on the first page of the service contract in not less than fourteen point modern type stating, "this is not an automobile liability insurance contract".

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973.

§1762. Solicitation for unauthorized club prohibited

No person shall solicit or aid in the solicitation of another person to purchase a service contract or membership issued by a club not having a valid certificate of authority.

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973.

§1763. Misrepresentation prohibited

No automobile club, officer or agent thereof shall in any manner misrepresent the terms, benefits or privileges of any service contract or membership issued or to be issued by it.

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973.

§1764. Validity of noncomplying forms

Any service contract or membership made, issued or delivered contrary to any provision of this act shall, nevertheless be valid and binding on the club.

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973.

§1765. Club agents; registration

Every automobile club operating in this state pursuant to a certificate of authority issued hereunder shall, within thirty days of the date of employment, file with the commissioner a notice of appointment of a club agent by an automobile club to sell memberships in the automobile club to the public. This notification shall be in a manner prescribed by the commissioner and shall contain the name, address, age, sex, and social security number of such club agent, and also contain proof satisfactory to the commissioner that such applicant is of good reputation and that he has received training from the club or is otherwise qualified in the field of automobile club services contracts, and the laws of this state pertaining thereto. Upon termination of any club agency employment by an automobile club, the club shall within thirty days thereafter notify the commissioner of such termination.

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973. Amended by Acts 1981, No. 663, §1; Acts 1983, 1st Ex. Sess., No. 23, §1; Acts 2001, No. 460, §1, eff. Jan. 1, 2002.

§1766. REPEALED BY ACTS 1993, No. 952, §5, eff. Jan. 1, 1994.

§1767. Annual statement required

Each authorized automobile club shall annually before March 1st file with the commissioner a true statement of its financial condition, transactions, and the affairs as of December 31st preceding. The statement shall contain such information as may be reasonably required by the commissioner, and shall be verified by the oaths of at least two of the automobile club's principal officers.

The commissioner may suspend or revoke the certificate of authority of any automobile club failing to file its annual statement when due or during any extension of time therefor which the commissioner, for good cause, may grant.

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973.

§1768. Advertising limitations; exemptions

A. Automobile clubs operating hereunder shall make no reference to their certificate of authority or approval from the commissioner in any advertising, circular, contract or membership card, nor shall automobile clubs advertise or describe their services in such a manner as would lead the public to believe such services include automobile insurance.

B. All automobile clubs operating pursuant to a certificate of authority issued hereunder shall be exempt from the operation of all insurance laws of this state, except where such laws are specifically incorporated herein by reference, and except that accidental injury and death benefits furnished members of such clubs shall be covered under a group policy issued to the automobile club for the benefit of its members and such policy shall be issued by a company licensed to write such insurance in this state. Any such group policy issued to the automobile club shall be evidence to the membership of the club by a certificate of participation in the group policy that shall state on the face of the certificate in at least fourteen point black bold face type that the certificate is only a "certificate of participation in an accidental injury and death group policy and is not automobile liability insurance coverage."

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973.

§1769. Violation of act; penalties; prosecution

Violations of any provisions of this part, the punishment for which is not otherwise specifically stated herein is declared to be a misdemeanor and is punishable by a fine of not less than ten dollars nor more than two thousand dollars, or by imprisonment for not more than one year or both fine and imprisonment at the discretion of the court, in addition to any other provisions for revocation, suspension or forfeiture of any license, power or privilege provided herein. If the commissioner has reason to believe that any person has violated any provision of this act for which criminal prosecution would be in order, he shall so inform the district attorney in whose parish any such purported violation may have occurred, who shall have the duty to prosecute the case, if, in his judgment a violation of law has occurred.

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973.

§1770. Rules and regulations

The commissioner may make rules and regulations to implement the provisions of this part.

Added by Acts 1972, No. 416, §1, eff. Jan. 1, 1973.

PART VIII. VEHICLE MECHANICAL BREAKDOWN INSURERS

§1800. Definitions

As used in this Part:

(1) "Commissioner" means the commissioner of insurance of the state of Louisiana.

(2) "Credit disability insurance" means insurance on a debtor to provide indemnity for payment becoming due on a specified loan or other credit transaction while the debtor is disabled as defined in the insurance policy or certificate issued to the debtor.

(3) "Mechanical reimbursement insurance" means an insurance policy issued to a motor vehicle dealer or authorized representative thereunto to insure the performance of a vehicle service contract issued to a consumer if the motor vehicle dealer or the issuer of a service contract becomes insolvent or ceases to do business, or a policy whereby the motor vehicle dealer or designee is fully reimbursed for any and all liability resulting from a service contract issued to a consumer, or an insurance policy whereby such insurance company shall reimburse said motor vehicle dealer after a defined deductible has been reached, or an insurance policy whereby the insurance company shall issue a policy directly to the consumer to insure for the mechanical breakdown or mechanical failure of a motor vehicle.

(4) "Person" means any individual person, firm, company, corporation, partnership or association which provides vehicle mechanical breakdown insurance in this state.

(5) "Reinsurer" as used in this Part, means a person licensed under this Part engaged in the reinsuring of mechanical reimbursement insurance, residual value insurance, or credit disability insurance policies, or any combination of kinds of insurance.

(6) "Vehicle" means any vehicle that is required to be titled pursuant to the Vehicle Certificate of Title Law (R.S. 32:701 et seq.).

(7) "Vehicle mechanical breakdown insurance policy" means any contract, agreement, or instrument whereby a person other than the owner, seller, or lessor of a vehicle assumes the risk of and/or the expense or portion thereof for the mechanical breakdown or mechanical failure of a motor vehicle and other customer assistance and convenience services, such as vehicle rental assistance, towing assistance, trip interruption, and roadside assistance, and shall include those agreements commonly known as vehicle service agreements or extended warranty agreements.

(8) "Vehicle mechanical breakdown insurer" means any person or organization, whether domestic, foreign or alien, issuing or attempting to issue vehicle mechanical breakdown policies as defined herein.

Added by Acts 1978, No. 520, §1, eff. July 12, 1978. Amended by Acts 1982, No. 638, §1; Acts 1986, No. 848, §1; Acts 2005, No. 100, §1.

§1801. License required of vehicle mechanical breakdown insurer

A. No person shall act as or attempt to act as a vehicle mechanical breakdown insurer unless licensed to do so by the commissioner. Each application shall be submitted to the commissioner along with the fee for said license in the amount of one thousand five hundred dollars. Licenses shall be renewed annually upon payment of a fee of one thousand five hundred dollars, due on January 1 of each year and which shall be paid no later than March 15 of the year in which due.

B. Each vehicle mechanical breakdown insurer may also act as a reinsurer in accordance with regulations adopted by the commissioner. All reserves for credit disability insurance shall be retained and held by the credit disability insurer.

Added by Acts 1978, No. 520, §1, eff. July 12, 1978. Acts 1986, No. 848, §1.

§1802. Exceptions

Nothing in this Part shall have any effect upon the giving of the customary manufacturer's warranty, or guarantee; nor shall this Part apply to or affect the giving or selling of performance warranties or guarantees by sellers of motor vehicles. Nothing in this Part shall be construed to prohibit the regulation of the selling of performance warranties or guarantees by sellers of motor vehicles as provided in R.S. 32:772 and 1253.

Added by Acts 1978, No. 520, §1, eff. July 12, 1978. Acts 1987, No. 710, §1.

§1803. Qualifications

The commissioner shall not issue a license as a vehicle mechanical breakdown insurer unless all of the following conditions are met:

(1) If the applicant is a corporation, it shall be a solvent corporation, incorporated under the laws of Louisiana, or another state, district, territory or possession of the United States of America.

(2) Applicant shall furnish such proof as necessary to the commissioner that the directors and management of the company are competent and trustworthy and are capable of successfully managing its affairs in compliance with law.

(3) Applicant shall make the deposit or file such surety as required by R.S. 22:1804, and

(4) Applicant shall be in compliance with and continue to be in compliance with all applicable laws.

Added by Acts 1978, No. 520, §1, eff. July 12, 1978.

§1804. Deposit or surety; required

A. To assure faithful performance of its obligations to policyholders, every vehicle mechanical breakdown insurer shall, prior to the issuance of a license, deposit with or for the benefit of the insurance commissioner, securities which, at all times shall have a value of not less than $150,000.

B. Those securities which may be used as a deposit shall be cash, certificates of deposit purchased from a financial institution licensed to conduct business in the state of Louisiana, bonds of the state of Louisiana or any of its political subdivisions, or bonds of the United States government.

C. In lieu of the deposit of securities required by this Section, the applicant may file with the commissioner a surety bond in the amount required by Subsection A of this Section. The bond shall be authorized by a surety insurer licensed to do business in the state of Louisiana, and shall be for the same purpose as the deposit in lieu of which it is filed and shall be subject to the approval of the commissioner. No such bond shall be cancelled or subject to cancellation unless thirty days written notice is given to the commissioner.

D. If deposit is made in the form of bonds or certificates of deposit, they shall be irrevocably pledged to the commissioner; provided however, that any interest earned on said securities shall be the property of applicant.

E. Each deposit or surety shall be maintained unimpaired, unencumbered, and pledged to the commissioner until such time as all outstanding policies or agreements of Louisiana have run their full term and expired. It is the intent of this Subsection that the deposit or surety remain fully in force until such time as all of the insurer's obligations to the policy holders are fulfilled.

F. The deposit or surety required by this Section may from time to time be substituted for with other acceptable securities, or surety bond, subject to the approval of the commissioner.

Added by Acts 1978, No. 520, §1, eff. July 12, 1978.

§1805. Annual reports

Each vehicle mechanical breakdown insurer shall, on or before the 15th day of March of each year, submit to the commissioner a report signed by the president and secretary which shall certify the premiums received by said insurer on risks located in this state for the preceding year. At the same time an annual report shall be submitted to the commission which clearly indicates the method being used to reserve for future losses and the amount in the reserve for the future losses. Each annual report shall be audited by a certified public accounting firm which is acceptable to the commissioner.

Added by Acts 1978, No. 520, §1, eff. July 12, 1978.

§1806. Reserves

Each vehicle mechanical breakdown insurer shall maintain loss reserves in such amounts as the commissioner deems sufficient.

Added by Acts 1978, No. 520, §1, eff. July 12, 1978.

§1807. Contracts not in compliance

Any vehicle mechanical breakdown insurance policy issued in violation of any provisions of this Part shall be an enforceable and valid contract unless otherwise invalid.

Added by Acts 1978, No. 520, §1, eff. July 12, 1978.

§1808. Revocation or suspension of license

The commissioner may revoke or suspend any license required by this Part after a hearing duly called for that purpose which is conducted pursuant to the provisions of the Administrative Procedure Act contained in Title 49 of the Louisiana Revised Statutes of 1950. Causes for revocation or suspension shall be the following:

(1) If any judgment in favor of a policy holder or his heir or assignees has become final and has not been paid in full within sixty days.

(2) If, in the opinion of the commission, the reserve for losses maintained by the insurer are insufficient to cover future losses.

(3) If, in the opinion of the commissioner, the insurer is insolvent.

(4) If the insurer refuses to allow inspection provided by R.S. 22:1810.

Added by Acts 1978, No. 520, §1, eff. July 12, 1978.

§1809. Inspection

After furnishing fourteen days written notice, the commissioner or any representative may inspect the records and reserves of any insurer licensed under this Part. The reasonable expense for inspection of records not available in Louisiana shall be borne by the insurer.

Added by Acts 1978, No. 520, §1, eff. July 12, 1978.

§1810. Cease and desist order; penalty for violation

A. If a hearing is held pursuant to the provisions of the Administrative Procedure Act in Title 49 of the Louisiana Revised Statutes of 1950 and if the commissioner should determine that the provisions of this Part have been violated, the commissioner shall, in addition to the authority to revoke or suspend a license as provided in R.S. 22:1809, have the authority to issue an order requiring such person or insurer violating the provisions of this Part, to cease and desist from such method, act, or practice. A written record shall be made of the commissioner's findings.

B. If, after issuing such cease and desist order, such person or insurer continues to violate the provisions of this Part, the commissioner may seek the enforcement of such order by civil legal action filed in the district court for the parish of East Baton Rouge. Any person who violates a cease and desist order of the commissioner after it has become final and while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the state of Louisiana a sum not to exceed five hundred dollars, except that, if such violation is found to be willful, the amount of such penalty shall be a sum not to exceed five thousand dollars.

C. The commissioner may issue a cease and desist order prior to a hearing in accordance with the Administrative Procedure Act as provided herein for violation of R.S. 22:1801 or 1805.

Added by Acts 1978, No. 520, §1, eff. July 12, 1978; Acts 1990, No. 657, §1.

§1811. Rules and regulations

The commissioner may adopt such administrative rules as are necessary to implement the provisions of this Part.

Added by Acts 1978, No. 520, §1, eff. July 12, 1978.

§1812. Scope and limitations

A. It is not the purpose of this Part to alter or diminish any right, privilege or authority granted to any insurance company under any other part or section of this Title.

B. All vehicle mechanical breakdown insurers operating pursuant to a license as required by this Part shall be exempt from the applicability of all other insurance laws of this state, except where such laws are specifically incorporated herein by reference.

Added by Acts 1978, No. 520, §1, eff. July 12, 1978.

PART IX. PROPERTY RESIDUAL VALUE INSURERS

§1900. Definitions

As used in this Part:

(1) "Commissioner" means the commissioner of insurance of the state of Louisiana.

(2) "Property" means all classes of movable or immovable property recognized under the laws of this state.

(3) "Person" means any individual person, firm, company, corporation, partnership, or association which provides property residual value insurance in this state.

(4) "Property residual value insurer" means any person or organization, whether domestic, foreign, or alien, issuing or attempting to issue property residual value policies as defined herein.

(5) "Property residual value insurance policy" means any contract, agreement, or instrument whereby a person, other than the owner, seller, lessee, or lessor of property, either directly or indirectly, assumes the risk of and/or the expense or portion thereof for the residual value of property, including but not limited to auto-gap* insurance.

(6) "Residual value" shall mean the value of property at a specific future time, which value is determined by agreement at the time the contract of lease or sale is entered into.

Added by Acts 1981, No. 472, §1, eff. July 19, 1981. Acts 1986, No. 849, §1; Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996.

*As appears in enrolled bill.

§1901. License required of property residual value insurer

No person shall act as or attempt to act as a property residual value insurer unless licensed to do so by the commissioner. Each application shall be submitted to the commissioner along with the fee for such license in the amount of one thousand five hundred dollars. Licenses shall be renewed annually upon payment of a fee of one thousand five hundred dollars, which shall be paid no later than March fifteenth of each year.

Added by Acts 1981, No. 472, §1, eff. July 19, 1981.

§1902. Exceptions

Nothing in this Part shall have any effect upon contracts of casualty or property insurance issued on property in this state.

Added by Acts 1981, No. 472, §1, eff. July 19, 1981.

§1903. Qualifications

The commissioner shall not issue a license as a property residual value insurer unless all of the following conditions are met:

(1) If the applicant is a corporation, it shall be a solvent corporation, incorporated under the laws of Louisiana or another state, district, territory, or possession of the United States.

(2) Applicant shall furnish such proof as necessary to the commissioner that the directors and management of the company are competent and trustworthy and are capable of successfully managing its affairs in compliance with law.

(3) Applicant shall make the deposit or file such surety as required by R.S. 22:1904.

(4) Applicant shall be in compliance with and continue to be in compliance with all applicable laws.

Added by Acts 1981, No. 472, §1, eff. July 19, 1981.

§1904. Deposit or surety

A. To assure faithful performance of its obligations to policyholders, every property residual value insurer shall, prior to the issuance of a license, deposit with or for the benefit of the insurance commissioner, securities which, at all times, shall have a value of not less than one hundred fifty thousand dollars.

B. Those securities which may be used as a deposit shall be cash, certificates of deposit purchased from a financial institution licensed to conduct business in the state of Louisiana, bonds of the state of Louisiana or any of its political subdivisions, or bonds of the United States government.

C. In lieu of the deposit of securities required by this Section, the applicant may file with the commissioner a surety bond in the amount of not less than one hundred fifty thousand dollars. The bond shall be authorized by a surety insurer licensed to do business in the state of Louisiana, shall be for the same purpose as the deposit in lieu of which it is filed, and shall be subject to the approval of the commissioner. No such bond shall be cancelled or subject to cancellation unless thirty days written notice is given to the commissioner.

D. If deposit is made in the form of bonds or certificates of deposit, they shall be irrevocably pledged to the commissioner; however, any interest earned on said securities shall be the property of depositor.

E. Each deposit or surety shall be maintained unimpaired, unencumbered, and pledged to the commissioner until such time as all outstanding policies have run their full term and expired. The deposit or surety shall remain fully in force until such time as all of the insurer's obligations to the policyholders are fulfilled.

Added by Acts 1981, No. 472, §1, eff. July 19, 1981.

§1905. Annual reports

Each property residual value insurer shall, on or before the fifteenth day of March of each year, submit to the commissioner a report signed by the president and secretary which shall certify the premiums received by said insurer on risks located in this state for the preceding year. At the same time an annual report shall be submitted to the commissioner which clearly indicates the method being used to reserve for future losses and the amount in the reserve for the future losses. Each annual report shall be audited by a certified public accounting firm which is acceptable to the commissioner.

Added by Acts 1981, No. 472, §1, eff. July 19, 1981.

§1906. Reserves

Each property residual value insurer shall maintain loss reserves in such amounts as the commissioner deems sufficient.

Added by Acts 1981, No. 472, §1, eff. July 19, 1981.

§1907. Contracts not in compliance

Any property residual value insurance policy issued in violation of any provisions of this Part shall be an enforceable and valid contract unless otherwise invalid.

Added by Acts 1981, No. 472, §1, eff. July 19, 1981.

§1908. Revocation or suspension of license

The commissioner may revoke or suspend any license required by this Part after a hearing duly called for that purpose conducted pursuant to the provisions of the Administrative Procedure Act contained in Title 49 of the Louisiana Revised Statutes of 1950. Any license issued under the provisions of this Part shall be revoked or suspended for the following causes:

(1) A judgment in favor of a policyholder or his heir or assignees has become final and has not been paid in full within sixty days.

(2) In the opinion of the commissioner the reserve for losses maintained by the insurer are insufficient to cover future losses.

(3) In the opinion of the commissioner, the insurer is insolvent.

(4) The insurer refuses to allow an inspection as provided in R.S. 22:1909.

Added by Acts 1981, No. 472, §1, eff. July 19, 1981.

§1909. Inspection

After furnishing fourteen days written notice, the commissioner or his representative may inspect the records and reserves of any insurer licensed under this Part. The reasonable expense for inspection of records not available in Louisiana shall be borne by the insurer.

Added by Acts 1981, No. 472, §1, eff. July 19, 1981.

§1910. Cease and desist order; penalty for violation

A. Following a hearing held pursuant to the provisions of the Administrative Procedure Act, if the commissioner determines that the provisions of this Part have been violated, he shall, in addition to the authority to revoke or suspend a license as provided in R.S. 22:1908, have the authority to issue an order requiring such person or insurer violating the provisions of this Part, to cease and desist from such method, act, or practice. A written record shall be made of the commissioner's findings.

B. If, after issuing such cease and desist order, such person or insurer continues to violate the provisions of this Part, the commissioner may seek the enforcement of such order by civil legal action filed in the Nineteenth Judicial District Court for the parish of East Baton Rouge. Any person who violates a cease and desist order of the commissioner after it has become final and while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the state of Louisiana a sum not to exceed five hundred dollars, except that, if such violation is found to be willful, the amount of such penalty shall be a sum not to exceed five thousand dollars.

C. The commissioner may issue a cease and desist order for violation of R.S. 22:1901 pending compliance with the Administrative Procedure Act as provided in this Section.

Added by Acts 1981, No. 472, §1, eff. July 19, 1981.

§1911. Rules and regulations

The commissioner may adopt such administrative rules and regulations as are necessary to implement the provisions of this Part.

Added by Acts 1981, No. 472, §1, eff. July 19, 1981.

§1912. Scope and limitations

A. Nothing in this Part shall alter or diminish any right, privilege, or authority granted to any insurance company under any other provisions of Title 22 of the Louisiana Revised Statutes of 1950.

B. All property residual value insurers operating pursuant to a license as required by this Part shall be exempt from the applicability of all other insurance laws of this state, except where such laws are specifically incorporated herein by reference.

Added by Acts 1981, No. 472, §1, eff. July 19, 1981.

PART X. EQUAL OPPORTUNITY IN INSURANCE

§1921. Division of minority affairs

There is hereby created within the Department of Insurance a division of minority affairs which shall have the following functions and duties:

(1) To assist in coordinating the activities of the Advisory Committee on Equal Opportunity.

(2) To maintain a list of a contact person within each insurance company transacting business in this state who is specifically charged with a duty by the company to respond to inquiries from members of minority groups regarding opportunities for employment, appointment as agents, and contracting for services with insurance companies.

(3) In cooperation with insurance companies transacting business in the state, to establish educational and informational services to foster a greater awareness of the opportunities available in the insurance industry and of the skills, training, and education necessary to prepare for opportunities in employment, appointment as agents, and contracting for services with insurance companies.

(4) To assist members of minority groups in obtaining employment, agent's or agency contracts, and contracting for services with insurance companies transacting business in Louisiana.

(5) To submit an annual report by April first of each year to the House and Senate insurance committees relative to educational and informational services made available to minorities, the number and types of inquiries, and all available relevant information from applicants and agents.

(6)(a) To develop a pilot program which seeks to address the needs and concerns of minority and women insurance agents in this state. The pilot program, at a minimum, shall provide training for agents in all areas of agency management, training and education for agency personnel, and automation support for the agents in the pilot program. The commissioner of insurance may adopt rules and regulations necessary for the implementation of the provisions of this Section.

(b) This Paragraph shall not apply to insurance agents who exclusively sell insurance for one company or a group of companies under common management which already has a training program in place for all agents.

Acts 1984, No. 850, §1; Acts 1992, No. 377, §1, eff. June 17, 1992; Acts 1993, No. 380, §1; Acts 1999, No. 885, §1, eff. June 30, 1999.

§1922. Advisory Committee on Equal Opportunity

A.(1) There is hereby created within the Department of Insurance, in the division of minority affairs, the Advisory Committee on Equal Opportunity. The committee shall be composed of fifteen members. Fourteen members shall be appointed by the governor and shall serve at his pleasure. The deputy commissioner for minority affairs shall serve ex officio as the fifteenth member. Four members shall be appointed from a list of nominees submitted by the Louisiana chapter of The National Association for the Advancement of Colored People, the Urban League of Greater New Orleans, Inc., the Baton Rouge chapter of the National Association for the Advancement of Colored People, and the Shreveport chapter of the National Association for the Advancement of Colored People. Two members shall be appointed from a list of nominees submitted by the deans of the business schools of Dillard University, Xavier University, Southern University, and Grambling University. Eight members shall be appointed from a list of nominees, one nominee to be submitted by each of the following associations or groups:

(a) Louisiana Insurers' Conference.
(b) American Council of Life Insurance.
(c) Life Insurers' Conference.
(d) National Association of Life Companies.
(e) Louisiana Association of Fire and Casualty Companies.
(f) National Association of Independent Insurers.
(g) American Insurance Association.
(h) Alliance of American Insurers.
(i) Health Insurance Association of America.
(j) Property and casualty insurers unaffiliated with the trade associations designated above.
(k) The state chapter of the Louis A. Martinet Society.
(l) National Independent Insurance Agents.
(m) Louisiana Realtists Association.
(n) National Business League, Louisiana chapter.
(o) An organization representing Hispanic Americans, as identified by the commissioner of insurance.
(p) An organization representing Asian Americans, as identified by the commissioner of insurance.
(q) An organization representing Native Americans, as identified by the commissioner of insurance.

(2) Each appointment by the governor shall be submitted to the Senate for confirmation.

(3) The committee shall serve without compensation, except for compensation for mileage and meals expenses incurred in connection with actual attendance at meetings of the committee or while on business of the committee assigned by the committee, but only when properly vouchered.

B. The committee shall assist the commissioner of insurance and the division of minority affairs in establishing educational and informational services to foster a greater awareness of the opportunities available in the insurance industry and of the skills, training, and education necessary to prepare for opportunities in employment, appointment as agents, and contracting for services with insurance companies transacting business in Louisiana. The commissioner of insurance shall promulgate rules and regulations to implement this Part.

C. The committee shall review all complaints alleging a violation of the provisions of this Part. Upon receipt of a complaint, the committee shall notify the insurer against whom the complaint was filed of the nature of the complaint and provide him with an opportunity to make a written explanation. As a part of the response, the insurer may submit to the committee any affirmative action plan it may have in effect. The committee shall consider any affirmative action plan submitted to it, along with any other pertinent information submitted to it, in determining whether the insurer has engaged in a pattern or practice of employment discrimination prohibited by R.S. 23:1006.

D. The committee shall report apparent violations of this Part to the commissioner of insurance, who may then, and only then, commence enforcement proceedings in accordance with R.S. 22:1923.

E. Nothing contained in this Section or in R.S. 22:1921 shall be construed to expand the coverage of R.S. 23:1006 for purposes of the sanctions authorized against insurers under R.S. 22:1923.

Acts 1984, No. 850, §1; Acts 1992, No. 1134, §1; Acts 1993, No. 89, §1; Acts 1999, No. 885, §1, eff. June 30, 1999; Acts 2001, No. 168, §1.

§1923. Sanctions

A. Whenever the commissioner of insurance receives notification of an apparent violation from the advisory committee, and determines, after notice and opportunity for a hearing in accordance with the Administrative Procedure Act, that an insurer has engaged in a pattern or practice of employment discrimination prohibited by R.S. 23:1006, he may issue an order requiring the insurer to cease and desist engaging in such unlawful act or practice. If the insurer does not comply with the cease and desist order, the commissioner may then:

(1) Require the insurer to file an affirmative action plan in accordance with rules and regulations adopted by the commissioner. If the insurer fails to file such affirmative action plan, the commissioner may then:

(2) Levy a civil penalty of up to ten thousand dollars against the insurer. If, after levy of such a fine, the violation still exists, the commissioner may then:

(3) Restrict the insurer's agency appointment powers.

B. Nothing in this Part shall be construed to authorize the commissioner to revoke a certificate of authority of any insurer for any violation of this Part.

C. The authority of the commissioner to impose any sanctions provided for in this Section shall not apply in any of the following instances:

(1) When there is an order or a conciliation agreement in effect rendered by a federal court or federal agency arising out of the same facts.

(2) When there is a complaint pending with a federal court or federal agency arising out of the same facts.

(3) When there is a complaint filed with the appropriate federal agency and with the commissioner under the provisions of this Part involving the same parties, with respect to the same subject matter, and arising out of the same facts or circumstances.

(4) When the insurer has an affirmative action plan. The plan shall contain the following minimum requirements:

(a) A stated purpose of the insurer to foster equal opportunities for minorities.

(b) The delineation of active steps and efforts by the insurer reasonably calculated to achieve the stated purpose.

Acts 1984, No. 850, §1.

PART XI. ANIMAL INSURERS

§1931. Definitions

As used in this Part:

(1) "Animal" means any animal other than man and includes fowl, birds, fish, and reptiles.

(2) "Animal insurance policy" means any contract, agreement, or instrument whereby a person other than the owner assumes the risk and/or the expense or any portion thereof for the health of an animal.

(3) "Animal insurer" means any person or organization, whether domestic, foreign, or alien issuing or attempting to issue animal insurance policies as defined herein.

(4) "Commissioner" means the commissioner of insurance of the state of Louisiana.

(5) "Person" means any individual person, firm, company, corporation, partnership, or association which provides animal insurance in this state.

Acts 1985, No. 563, §1.

§1932. License required of animal insurer

Except as otherwise provided herein, no person shall act as or attempt to act as an animal insurer unless licensed to do so by the commissioner. Each application shall be submitted to the commissioner along with a license fee of one thousand five hundred dollars. Licenses shall be renewed annually upon payment of a fee of one thousand five hundred dollars, due on January 1 of each year, and which shall be paid no later than March 15 of the year in which due.

Acts 1985, No. 563, §1.

§1933. Exceptions

Nothing in this Part shall apply to or affect the giving or selling of warranties or guarantees by sellers of animals.

Acts 1985, No. 563, §1.

§1934. Qualifications

The commissioner shall not issue a license to an animal insurer unless all of the following conditions are met:

(1) If the applicant is a corporation, it shall be a solvent corporation incorporated under the laws of Louisiana or another state, district, territory, or possession of the United States of America.

(2) Applicant shall furnish such proof as is necessary to the commissioner that the directors and management of the company are competent, trustworthy, and capable of successfully managing its affairs in compliance with law.

(3) Applicant shall deposit securities or file a surety bond as required by R.S. 22:1935.

(4) Applicant shall be in compliance with and continue to comply with all applicable laws.

Acts 1985, No. 563, §1.

§1935. Deposit or surety; required

A. To assure faithful performance of its obligations to policyholders, every animal insurer, prior to the issuance of a license, shall deposit with or for the benefit of the insurance commissioner securities which at all times shall have a value of not less than one hundred fifty thousand dollars.

B. Those securities which may be used as a deposit shall be cash, certificates of deposit purchased from a financial institution licensed to conduct business in the state of Louisiana, bonds of the state of Louisiana or any of its political subdivisions, or bonds of the United States government.

C. In lieu of the deposit of securities required by this Section, the applicant may file with the commissioner a surety bond in the amount required by Subsection A of this Section. The bond shall be authorized by a surety licensed to do business in the state of Louisiana, shall be for the same purpose as the deposit in lieu of which it is filed, and shall be subject to the approval of the commissioner. No such bond shall be cancelled or subject to cancellation unless thirty days written notice is given to the commissioner.

D. If deposit is made in the form of bonds or certificates of deposit, they shall be irrevocably pledged to the commissioner; provided that any interest earned on the securities shall be the property of the applicant.

E. Each deposit or surety shall be maintained unimpaired, unencumbered, and pledged to the commissioner until such time as all outstanding policies or agreements in Louisiana have run their full term and expired. It is the intent of this Subsection that the deposit or surety remain fully in force until such time as all of the insurer's obligations to the policyholders are fulfilled.

F. The deposit or surety required by this Section may from time to time be substituted with other acceptable securities or surety bond, subject to the approval of the commissioner.

Acts 1985, No. 563, §1.

§1936. Annual reports

Each animal insurer on or before the fifteenth day of March of each year, shall submit to the commissioner a report certifying the premiums received by the insurer on risks located in this state for the preceding year. At the same time an annual report shall be submitted to the commissioner which clearly indicates the method being used to provide reserves for future losses and the amount currently in reserve. Each annual report shall be audited by a certified public accounting firm acceptable to the commissioner.

Acts 1985, No. 563, §1.

§1937. Reserves

Each animal insurer shall maintain loss reserves in such amounts as the commissioner considers sufficient.

Acts 1985, No. 563, §1.

§1938. Contracts not in compliance

Any animal insurance policy issued in violation of any provisions of this Part shall be an enforceable and valid contract unless otherwise invalid.

Acts 1985, No. 563, §1.

§1939. Revocation or suspension of licenses

The commissioner may revoke or suspend any license required by this Part after a hearing duly called for that purpose which is conducted pursuant to the provisions of the Administrative Procedure Act. Causes for revocation or suspension shall be the following:

(1) Any judgment in favor of a policyholder or his heirs or assignees has become final and has not been paid in full within sixty days.

(2) In the opinion of the commissioner, the reserve for losses maintained by the insurer is insufficient to cover future losses.

(3) In the opinion of the commissioner, the insurer is insolvent.

(4) The insurer refuses to allow inspection provided by R.S. 22:1940.

Acts 1985, No. 563, §1.

§1940. Inspection

After furnishing fourteen days written notice, the commissioner or his representative may inspect the records and reserves of any insurer licensed under this Part. The reasonable expense for inspection of records not available in Louisiana shall be borne by the insurer.

Acts 1985, No. 563, §1.

§1941. Cease and desist order; penalty for violation

A. If a hearing is held pursuant to the provisions of the Administrative Procedure Act and if the commissioner determines that any provision of this Part has been violated, the commissioner, in addition to the authority to revoke or suspend a license as provided in R.S. 22:1939, shall have the authority to issue an order requiring such person or insurer violating any provision of this Part to cease and desist from such method, act, or practice. A written record shall be made of the commissioner's findings.

B.(1) If after issuing such cease and desist order the person or insurer continues to violate a provision of this Part, the commissioner may seek the enforcement of such order by civil action filed in the Nineteenth Judicial District Court.

(2) Any person who is found by the court to have violated a cease and desist order of the commissioner after it has become final and while such order is in effect, shall forfeit and pay to the state of Louisiana a sum not to exceed five hundred dollars, except that, if such violation is found to be willful, the amount of the penalty shall be a sum not to exceed five thousand dollars.

Acts 1985, No. 563, §1.

§1942. Rules and regulations

The commissioner may adopt such administrative rules as are necessary to implement the provisions of this Part.

Acts 1985, No. 563, §1.

§1943. Scope and limitation

A. It is not the purpose of this Part to alter or diminish any right, privilege, or authority granted to any insurance company to write casualty insurance on the life or health of animals under any other Part or Section of this Title.

B. All animal insurers operating pursuant to a license as required by this Part shall be exempt from the applicability of all other insurance laws of this state, except where such laws are specifically incorporated herein by reference.

C. The provisions of this Part shall not apply to the insuring of the life or health of large animals having a gross weight of three hundred pounds or more at maturity.

Acts 1985, No. 563, §1.

PART XII. HEALTH MAINTENANCE ORGANIZATIONS

§2001. Short title

This Part may be cited as the Health Maintenance Organization Act.

Acts 1986, No. 1065, §1.

§2002. Definitions

As used in this Part:

(1) "Commissioner" means the commissioner of insurance.

(2) "Secretary" means the secretary of the Department of Health and Hospitals.

(3) "Basic health care services" means emergency care, inpatient hospital and physician care, outpatient medical and chiropractic services, and laboratory and x-ray services. The term shall include optional coverage for mental health services for alcohol or drug abuse. With respect to chiropractic services, such services shall be provided on a referral basis at the request of the enrollee who presents a condition of an orthopedic or neurological nature necessitating referral, the treatment for which falls within the scope of a licensed chiropractor. Effective January 1, 2004, the term shall also include coverage for low protein food products as provided in R.S. 22:2004.2.

(4) "Enrollee" means an individual who is enrolled in a health maintenance organization.

(5) "Evidence of coverage" means any certificate, agreement, or contract issued to an enrollee setting out the coverage to which the enrollee is entitled by reason of payment of a prepaid charge.

(6) "Health care services" means any services rendered by providers which include but are not limited to medical and surgical care; psychological, optometric, optic, chiropractic, podiatric, nursing, and pharmaceutical services; health education, rehabilitative, and home health services; physical therapy; inpatient and outpatient hospital services; dietary and nutritional services; laboratory and ambulance services; and any other services for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability. Health care services shall also mean dental care, limited to oral and maxillofacial surgery as performed by board qualified oral and maxillofacial surgeons. Effective January 1, 1992, the term shall also include an annual Pap test for cervical cancer and minimum mammography examination as defined in R.S. 22:215.11. Effective January 1, 2004, the term shall also include coverage for low protein food products as provided in R.S. 22:2004.2.

(7) "Health maintenance organization" means any corporation organized and domiciled in this state which undertakes to provide or arrange for the provision of basic health care services to enrollees in return for a prepaid charge. The health maintenance organization may also provide or arrange for the provision of other health care services to enrollees on a prepayment or other financial basis. A health maintenance organization is deemed to be an insurer for the purposes of R.S. 22:213.6 and 213.7, Part XVI, comprised of R.S. 22:731 through 774, Part XXI-A, comprised of R.S. 22:1001 through 1015, and Part XXVI-B, comprised of R.S. 22:1241 through 1247.1, of Chapter 1 of this Title. A health maintenance organization shall not be considered an insurer for any other purpose.

(8) "Provider" means any physician, hospital, or other person, organization, institution, or group of persons licensed or otherwise authorized in this state to furnish health care services.

(9) "Subscriber" means the person who is responsible for payment to a health maintenance organization or whose employment or other status, except for family dependence, is the basis for eligibility for enrollment in the health maintenance organization.

(10) "Point of service policy" means any policy of coverage that meets the definition of a health and accident insurance policy pursuant to Parts VI and XIV of Chapter 1 of this Title.

Acts 1986, No. 1065, §1; Acts 1989, No. 666, §1, eff. Sept. 1, 1989; Acts 1991, No. 387, §1; Acts 1991, No. 994, §1; Acts 1992, No. 316, §1; Acts 1995, No. 1231, §1, eff. Sept. 1, 1995; Acts 1997, No. 1418, §1; Acts 1999, No. 878, §1, eff. July 2, 1999; Acts 2003, No. 829, §1.

§2003. Incorporation

A. Three or more artificial or natural persons capable of contracting, who are citizens of the United States and a majority of whom are residents of this state, may act as incorporators to form a corporation for the purpose of transacting business as a health maintenance organization.

B. Articles of incorporation shall be executed by authentic act signed by each of the incorporators and shall state in the English language:

(1) The name of the corporation, which shall not be the same as nor deceptively similar to the name of any other unaffiliated health maintenance organization authorized to do business in this state unless:

(a) Such other health maintenance organization is about to change its name or to cease to do business or is being wound up, and the written consent of such other health maintenance organization to the adoption of its name or a deceptively similar name has been given in writing and is filed with the articles, or

(b) Such other health maintenance organization has heretofore been authorized to do business in this state for more than two years and has never actively engaged in business.

(2) The purpose or purposes for which it is formed.

(3) Its duration.

(4) The location and post office address of its registered office.

(5) The full names and post office addresses of its registered agents for service of process.

(6) The amount of paid-in capital and minimum surplus, or initial fund, with which the corporation will begin business.

(7) The number of authorized shares, the par value of each share, the time when and the manner in which payment on stock subscribed shall be made.

(8) The names of the first directors, their post office address, and their classification and terms of office if they be named in the articles. Where the first board of directors is not named in the articles, the articles shall provide the place where and the date when the organization is to be perfected, and a meeting of the stockholders for that purpose must be held not more than sixty days after the execution of the articles. At that meeting the directors shall be elected.

(9) The name and post office address of each of the incorporators, and a statement of the number and class of shares subscribed by each, which shall not be less than one.

(10) The designation of general officers, the number of directors, which shall not be less than three nor more than fifty, and the mode and manner in which directors shall be elected, and officers elected or appointed.

(11) Any other provision for the regulation of the business and the conduct of the affairs of the corporation, not prohibited by the laws of this state.

C. Such articles shall be submitted to the commissioner for his examination for a period not to exceed thirty days from receipt and approval either before or after execution, but before recordation. The commissioner shall not approve such articles unless they strictly conform with the provisions of this Part.

D.(1) After the payment of all fees owed to the Department of Insurance, the articles showing the approval of the commissioner shall be filed in the office of the secretary of state by the commissioner together with an initial report, as prescribed by R.S. 12:101. If the first directors are not named in the articles of incorporation and the initial report, a supplemental report, setting forth their names and addresses, and signed by each incorporator or by any shareholder, shall be filed with the secretary of state and filed for record as provided by Subsection D(4) of this Section as soon as they have been selected.

(2) If the secretary of state finds that the articles have been approved by the commissioner and that the articles and initial report are in compliance with this Part and Title 12 of the Louisiana Revised Statutes, and after all fees have been paid as required by law, the secretary of state shall record the articles and the initial report in his office, endorse on each the date and, if requested, the hour of filing thereof with him, and issue a certificate of incorporation that shall show the date and, if endorsed on the articles, the hour of filing of the articles with him. The certificate of incorporation shall be conclusive evidence of the fact that the corporation has been duly incorporated except that in any proceeding brought by the state to annul, forfeit, or vacate a corporation's franchise, or by the commissioner to prohibit, suspend or limit the corporation's right to conduct business as a health maintenance organization, the certificate of incorporation shall be only prima facie evidence of due incorporation.

(3) Upon the issuance of the certificate of incorporation, the corporation shall be duly incorporated, and the corporate existence shall begin, as of the time when the articles were filed with the secretary of state.

(4) A multiple original of the articles or a copy certified by the secretary of state, with a copy of the certificate of incorporation, and a multiple original of the initial report, or a copy certified by the secretary of state, shall be filed in the office of the recorder of mortgages of the parish in which the registered office of the corporation is situated, and a certified copy of the articles and initial report, bearing the certificate of the proper parish recorder with a copy of the certificate of incorporation, shall be filed with the commissioner.

(5) The corporation shall not have authority to transact a health maintenance organization business until a certificate of authority to transact such business is issued to it by the commissioner.

E.(1) Except as otherwise provided in the articles of incorporation, an incorporated health maintenance organization may amend its articles of incorporation in the manner provided in R.S. 12:31.

(2) After such amendment has been duly adopted, an authentic act setting forth the amendment and the manner of adoption thereof shall be executed by such person or persons authorized to do so at the meeting. A full copy of the resolution adopting such amendment, certified as true copy by the secretary of the health maintenance organization, shall be annexed to the authentic act. The articles of amendment shall be approved by the commissioner and recorded with the secretary of state, the recorder of mortgages, and the commissioner, in the same manner as that provided herein for the original articles of incorporation.

(3) The provisions of Subsections (E)(1) and (2) of this Section shall not be applicable when an incorporated health maintenance organization changes either its registered agent or address, or both. In any such change, the incorporated health maintenance organization shall provide the commissioner with the board resolution and notice, and shall follow the requirements of Part X of Chapter 1, Title 12 of the Louisiana Revised Statutes of 1950.

F. The provisions of R.S. 12:1 through R.S. 12:178, and other provisions of the Louisiana Revised Statutes of 1950, relative to business corporations, shall apply to the regulation of the business and the conduct of the affairs of any health maintenance organization which has been incorporated pursuant to the provisions of this Part. If a conflict exists between the provisions of this Part and said provisions of Title 12, the provisions of this Part shall govern.

Acts 1986, No. 1065, §1; Acts 1999, No. 342, §6.

§2004. Application for certificate of authority to do business as a health maintenance organization in this state

A. Notwithstanding any other provision of law to the contrary, an application for a certificate of authority shall be made by the corporation to the commissioner in compliance with Subsection C of this Section. No corporation or other person or legal entity shall establish or operate a health maintenance organization in this state without having first obtained a certificate of authority to do so under this Part.

B. Every health maintenance organization holding a certificate of authority issued by the commissioner prior to the effective date of this Part, may continue to operate as a health maintenance organization under this Part, provided that, within ninety days of the effective date, each health maintenance organization in existence on the effective date shall file with the commissioner any additional documents required by Subsection C of this Section that have not been previously filed and shall take the actions necessary for full compliance with this Part. Health maintenance organizations organized prior to the effective date of this Part and doing business as a Louisiana partnership shall not be required to become a corporate entity, and shall be deemed to meet and satisfy the definition of health maintenance organizations under R.S. 22:2002(7). The additional filings shall constitute a reapplication for certification and each such health maintenance organization may continue to operate until the commissioner acts upon said reapplication. In the event that a health maintenance organization in existence on the effective date of this Part fails to timely file the additional documents and take the additional actions necessary for full compliance, the commissioner may suspend or revoke the health maintenance organization's certificate of authority as provided in R.S. 22:2013.

C. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner, and shall set forth or be accompanied by the following:

(1) A copy of the bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant.

(2) Biographical background information, on a form prescribed by the commissioner, for all of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, the principal officers, and each shareholder with over ten percent interest.

(3) A copy of the contract or the form of any contract made, or to be made, between the applicant and any provider of health care services or between the applicant and those persons listed in Paragraph (2) of this Subsection. The payment rendered or to be rendered to such provider or person shall be deemed confidential and shall not be divulged by the commissioner, or his staff, except that payment may be disclosed and become public record in any legislative, administrative, or judicial proceeding or inquiry.

(4) A statement describing the applicant's method of providing for health care services and describing the professional services to be rendered. This statement shall include the health care delivery capabilities of the plan including the number of primary physicians, the number of nonprimary physicians identified by specialty, the numbers and types of licensed health care support staff, and the number of contracted hospitals. For purposes of this subdivision, primary physicians may include general and family practitioners, internists, pediatricians, obstetricians, and gynecologists.

(5) A copy of the form of evidence of coverage to be issued to the enrollees.

(6) A copy of the form of the individual contract which is to be issued to individual subscribers and the form of the group contract which is to be issued to employers, unions, trustees, or other organizations. These contracts shall provide coverage for basic health care services and may at the option of the health maintenance organization, provide coverage for other health care services.

(7) Financial statements verified by an officer or other authorized representative of the applicant showing the applicant's assets, liabilities, and sources of financial support. The commissioner may require that the financial statements be made on forms prescribed by the National Association of Insurance Commissioners. If the applicant's financial affairs are audited by independent certified accountants, a copy of the applicant's most recent certified financial statement shall be deemed to satisfy this requirement unless the commissioner directs that additional or more recent financial information is required for the proper administration of this Part.

(8) A description of the proposed method of marketing.

(9) A financial plan which includes a projection of operating results anticipated until the organization has had a net income for at least one year.

(10) A statement as to the sources of working capital as well as any other sources of funding.

(11) A statement reasonably describing the geographic service area or areas to be served by the health maintenance organization; this statement shall also include a listing of principal and other offices maintained in this state by the health maintenance organization.

(12) A description of the enrollee grievance procedures to be utilized which comply with R.S. 22:2022.

(13) A description of the procedures and programs for internal review of the quality of health care. Such procedures and programs shall demonstrate adherence to nationally recognized standards which will reasonably lead to plan accreditation under standards recognized by the commissioner. The description of procedures and programs for internal review of the quality of health care shall include an accreditation plan outlining the steps being taken to become fully accredited.

(14) Reinsurance, stop loss, and excess loss insurance or agreements, if any.

(15) A fidelity bond or evidence of insurance which meets the requirements of R.S. 22:2007(B).

D.(1) An applicant, or a health maintenance organization holding a certificate of authority granted hereunder, unless otherwise provided for in this Part, shall file a notice describing any material modification of the operation. A material modification shall be a change in operations as follows:

(a) A change of ten percent or more of the ownership of the health maintenance organization.

(b) A reduction or expansion of twenty percent or more in the service area of the health maintenance organization.

(c) A change in the evidence of coverage.

(d) A change in the individual contract or the group contract.

(e) A change in reinsurance, stop loss, or excess loss insurance or agreements.

(f) A change in the accreditation standing of the plan or, in the case of a plan which is in the process of being accredited, a change in the accreditation plan approved by the commissioner.

(2) The notice shall be filed with the commissioner prior to the modification. If the commissioner does not disapprove the proposed modification within thirty days of filing, or request a thirty day extension in writing, the modification shall be deemed approved.

Acts 1986, No. 1065, §1; Acts 1995, No. 1231, §1, eff. Sept. 1, 1995; Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996; Acts 1997, No. 238, §1, eff. June 16, 1997.

§2004.1. Hearing impaired interpreter expenses; requirement

As a requirement for authorization to do business in this state pursuant to R.S. 22:2004, all health maintenance organizations shall provide coverage for expenses incurred by any hearing impaired enrollee for services performed by a qualified interpreter/transliterator, other than a family member of the enrollee, when such services are used by the enrollee in connection with medical treatment or diagnostic consultations performed by a health care provider.

Acts 1997, No. 1313, §1; Acts 1997, No. 1324, §1.

§2004.2. Inherited metabolic diseases; coverage for food products

A. Every health maintenance organization granted a certificate of authority under this Part and every insurer licensed under the provisions of Part IV of Chapter 1 of this Title that engages in health maintenance organization activities authorized and regulated pursuant to this Part shall provide coverage to each enrollee or family member of an enrollee, subject to applicable deductibles, coinsurance, and copayments, for low protein food products for treatment of inherited metabolic diseases, if the low protein food products are medically necessary and, if applicable, are obtained from a source approved by the health maintenance organization or health insurer, provided coverage will not be denied if the health maintenance organization or health insurer does not approve a source.

B. As used in this Section, the following words shall have the following meanings:

(1) "Inherited metabolic disease" shall mean a disease caused by an inherited abnormality of body chemistry. These diseases shall be limited to:

(a) Glutaric Acidemia.
(b) Isovaleric Acidemia (IVA).
(c) Maple Syrup Urine Disease (MSUD).
(d) Methylmalonic Acidemia (MMA).
(e) Phenylketonuria (PKU)
(f) Propionic Acidemia.
(g) Tyrosinemia.
(h) Urea Cycle Defects.

(2) "Low protein food products" shall mean a food product that is especially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. Low protein food products shall not include a natural food that is naturally low in protein.

C. Coverage provided pursuant to this Section shall not exceed eligible benefits of two hundred dollars per month.

D. The provisions of this Section shall apply to any new policy, contract, program, or plan issued by an entity subject to the provisions of this Section on or after January 1, 2004. Any such policy, contract, program, or plan in effect prior to January 1, 2004, shall convert to the provisions of this Section on or before the renewal date thereof but in no event later than January 1, 2005.

Acts 2003, No. 829, §1.

§2004.3. Reimbursement for chiropractic services

Notwithstanding any provision of any policy or contract of insurance or health benefits issued by a health maintenance organization after the effective date of this Section, whenever such policy or contract provides for payment or reimbursement for any service, and such service may be legally performed by a chiropractor licensed in this state, such payment or reimbursement under such policy or contract shall not be denied when such service is rendered by a person so licensed. Terminology in such policy or contract deemed discriminatory against any such person or method of practice shall be void.

Added by Acts 2005, No. 395, §1.

§2005. Issuance of certificate of authority

A. Within ninety days of receipt of a completed application, the commissioner shall issue a certificate of authority to do business in the state to a corporation filing an application and paying the prescribed fees, if the commissioner determines that the following conditions are met:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations.

(2) The applicant will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for co-payments.

(3) The applicant is financially responsible and may be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may consider:

(a) The financial soundness of the arrangements for health care services and the schedule of charges used in connection therewith.

(b) The adequacy of working capital.

(c) Any agreement with an insurer, a hospital or medical service corporation, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization.

(d) Any agreement between a health maintenance organization and providers for the provision of health care or other related services which holds the enrollee harmless from liability of any kind to the provider or any other third party for services rendered to the enrollee.

(e) Any deposit of cash or securities submitted in accordance with R.S. 22:2010.

B. A copy of each certificate of authority shall be filed by the commissioner with the secretary.

C. Every certificate of authority issued under this Part shall remain in effect until revoked or suspended by the commissioner.

Acts 1986, No. 1065, §1.

§2006. Powers of health maintenance organizations

Subject to the provisions of R.S. 22:2016(E) and regulations adopted and approved by the commissioner, the powers of a health maintenance organization include but are not limited to the following:

(1) The power to purchase, lease, construct, renovate, operate, or maintain hospitals, medical facilities, nursing care and intermediate care facilities, their ancillary equipment, and such property, including the stock of corporations, as may reasonably be required for its administrative offices or for such other purposes as may be necessary in the transaction of the business of the health maintenance organization.

(2) The power to make secured or guaranteed loans to providers under contract with the health maintenance organization in furtherance of its operations or the making of the loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities, hospitals, nursing care and intermediate care facilities, and other institutions of like nature providing health care services to enrollees, or in furtherance of a program providing health care services to its enrollees.

(3) The power to furnish health care services through providers which are under contract with or employed by the health maintenance organization.

(4) The power to contract with any person for the performance on its behalf of certain functions such as marketing, enrollment, and administration.

(5) The power to contract with an insurance company licensed to do business in this state or with a hospital or medical service corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization.

(6) The power to offer other health care services in addition to basic health care services.

(7) The power to coordinate benefits, subrogate to third party funds,* and engage in the assignment of claims to the extent that insurers are permitted to do so by the laws of this state.

(8) The power to issue point of service policies that have been approved by the commissioner to groups and individuals. The indemnity exposure of such policies shall conform to the same solvency requirements for claim reserves that are required of accident and health insurance companies licensed to operate in this state.

Acts 1986, No. 1065, §1; Acts 1999, No. 878, §1, eff. July 2, 1999.

*As Appears in the enrolled act.

§2007. Fiduciary duties of certain persons; bond required; encumbering assets

A. Any director, officer, or employee of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of such health maintenance organization shall be responsible for such funds in a fiduciary relationship to the health maintenance organization.

B. A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than one hundred thousand dollars or insurance in a form satisfactory to the commissioner in lieu of such bond. All such bonds or insurance shall be written with at least a one year discovery period and if written with less than a three year discovery period shall contain a provision that no cancellation or termination of the bond or insurance, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of ninety days after written notice of such cancellation or termination has been filed with the commissioner, unless an earlier date of such cancellation or termination is approved by the commissioner.

C. No asset of a health maintenance organization may be encumbered, pledged, or utilized to secure a loan or to confer a personal benefit on any officer, director, employee, agent, stockholder, or any beneficiary of any trust of any other person responsible to the health maintenance organization; however, nothing herein contained shall prevent any such person from receiving benefits as an enrollee. Any person and any officer, director, employee, agent, partner, stockholder, or any beneficiary of any trust violating this provision shall be fined two times the amount of the benefit conferred but not less than ten thousand dollars and shall be removed forthwith from any office, position, capacity, or relationship with the health maintenance organization.

D. In the event any situation described in Subsection C of this Section occurs, the commissioner shall have a cause of action and standing to sue to recover and conserve such property.

Acts 1986, No. 1065, §1.

§2007.1. Books and records of health maintenance organizations

A. Every health maintenance organization shall maintain the books and records relating to activities conducted in the state in its offices within the state pursuant to the provisions of this Part.

B. If books and records, other than those required by Subsection A, to be located in the state, are located outside the state, the health maintenance organization shall make the records and books available to the commissioner at a location within this state or pay reasonable and necessary expenses for the commissioner or his representative to examine them at the place where the records and books are maintained. The commissioner may designate representatives, including comparable officials of the state in which the records are located, to inspect the books and records on behalf of the commissioner.

Acts 1995, No. 1231, §1, eff. Sept. 1, 1995.

§2008. Annual report

A. On or before the first day of March, every health maintenance organization shall annually file a report with the commissioner covering the preceding calendar year and shall file a copy of the report with the secretary of the Department of Health and Hospitals. The report shall be verified by at least two principal officers or duly authorized representatives of the health maintenance organization. The report shall be on forms prescribed by the National Association of Insurance Commissioners. The report shall be accompanied by the filing fee and any penalty for unauthorized late filing set forth in R.S. 22:2024.

B. The commissioner for good cause may grant an extension of up to thirty days for the filing of the annual report.

C. In addition to Subsection A of this Section, the following reports shall also be filed with the commissioner:

(1) Quarterly statements as required by R.S. 22:1451.

(2) Management and discussion reports as required by R.S. 22:1451 and the National Association of Insurance Commissioners Annual Statement Instructions Handbook.

(3) A CPA audited report as required by R.S. 22:1324 and Regulation 50 issued by the Department of Insurance.

(4) Holding Company Act filings as required under Part XXI-A of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950.

Acts 1986, No. 1065, §1; Acts 1995, No. 1231, §1, eff. Sept. 1, 1995.

§2009. Investments

With the exception of investments made in accordance with R.S. 22:2006(1) and (2) a health maintenance organization shall be restricted to making the same types of investments as permitted for the investment of assets by life insurance companies licensed to do business in this state.

Acts 1986, No. 1065, §1.

§2010. Protection against insolvency

A. Prior to the issuance of any certificate of authority, each health maintenance organization applying therefor shall deposit with the commissioner a safe keeping receipt or trust receipt from banking corporations doing a banking business within the state of Louisiana or from a savings and loan association or other insured financial institution chartered to do business in the state of Louisiana, evidencing that the health maintenance organization has deposited with the several institutions one million dollars in cash to guarantee its financial responsibility. No single deposit shall exceed the insured deposit limit of any financial depository.

B. Each certificate or other evidence of deposit or security shall contain a restriction which reads as follows, to wit:

ACKNOWLEDGMENT OF RESTRICTION

The cash or other deposit evidenced by this certificate shall be held by the issuer, its successors, and assigns, to demonstrate to the Louisiana Department of Insurance that the owner-payee of the certificate is financially responsible and capable of performing its obligations as a health maintenance organization. This certificate shall be renewed and renegotiated between the issuer and the owner-payee without the necessity of the certificate's release or surrender and funds evidenced hereby shall remain on deposit at or with the issuing institution, its successors or assigns, until notice of release or a demand of payment signed by the duly authorized elected incumbent commissioner of insurance of the state of Louisiana, or his duly authorized deputy, has been presented to issuer. Any issuer making payment to the commissioner upon his written demand and upon a showing of good cause shall not be liable in any manner to the owner-payee or any other person for having made such disbursements of funds. Interest earned on the funds evidenced hereby shall be paid to the owner-payee on a regular periodic basis as agreed to by the issuer and the owner-payee.

C. Each health maintenance organization shall establish prior to the issuance of any certificate of authority, and shall maintain as long as it does business in Louisiana as a health maintenance organization, the following capital and surplus requirements:

(1) For each health maintenance organization which, by July 1, 1995, has not filed its application for a certificate of authority with the commissioner as required by law, a minimum of the greater of three million dollars or the amounts required by Part XII-B of this Chapter. The million dollar deposit required pursuant to R.S. 22:2010(A) shall apply as a part of this minimum requirement.

(2) For each health maintenance organization which, by July 1, 1995, has filed its application for a certificate of authority with the commissioner as required by law, the minimum capital and surplus shall be:

(i) Eight hundred thousand dollars by July 1, 1996.

(ii) One million five hundred thousand dollars by July 1, 1997.

(iii) Two million dollars by July 1, 1998.

D.(1) In lieu of the one million dollar aggregate deposit or deposits provided by Subsection A, each health maintenance organization applying for a certificate of authority may deposit with the commissioner an irrevocable letter or letters of credit issued in his favor in the amount of one million dollars in the aggregate, which shall be issued and maintained subject to the terms and conditions hereinafter set forth. The letter or letters of credit shall be issued by a banking corporation doing a banking business within the state of Louisiana or a savings and loan association or other insured financial institution chartered to do business in the state of Louisiana.

(2) Each letter of credit shall be issued for a term of three years from date thereof. Once issued, the letter or letters of credit shall not be cancelled regardless of the financial status of the applicant or the bank during the term thereof. Every letter of credit shall contain the following restrictions, to wit: After the initial three-year term, the letter or letters of credit shall be automatically extended, renewed, and reissued from year to year unless notice to the contrary by the issuing bank or institution is given to the commissioner by registered mail not less than ninety days prior to the expiration date. Upon receipt of notice that the letter or letters of credit will not be renewed, the commissioner shall have the following options:

(a) He may convert the letter or letters of credit to a cash deposit by calling for funding or payment in full thereon;

(b) He may accept a substitute letter or letters of credit if they meet all requirements of this Part; or

(c) He may convert the letter or letters of credit to a cash deposit and suspend the certificate of authority as provided by R.S. 22:2013.

E. After three years of successful operations, the commissioner may, but is not required to, waive or release up to twenty-five percent of the aggregate total deposits or letters of credit requirement set forth in Subsections A and D of this Section whenever he is satisfied that the organization has sufficient net worth and an adequate history of generating net income to assure its financial viability, or that its performance and obligations are reasonably guaranteed by an organization with sufficient net worth and with an adequate history of generating net income, or that the assets of the organization or its contracts with insurers, hospital or medical service corporations, governments, or other organizations are sufficient to reasonably assure the performance of its obligations as a health maintenance organization, to fully protect all enrollees, and to guarantee the services to which all enrollees are entitled.

F.(1) No letter or letters of credit issued or other security provided for herein shall be revoked, cancelled, terminated, substituted, or withdrawn by any issuing bank or financial institution without the written approval of, and ninety days prior written notice to, the commissioner at his office in Baton Rouge, such notices to be given by registered mail return receipt requested. Upon receipt of any such notice, the commissioner may exercise the powers and options granted hereinabove with respect to the letter or letters of credit. Upon a final decision of which option the commissioner will exercise, he shall give written notice by registered mail to the issuing bank or institution and the health maintenance organization at least ten days prior to termination of the letter or letters of credit. The issuer of the letter or letters of credit shall fully fund the letter or letters of credit within twenty-four hours after receipt of notice to do so from the commissioner.

(2) Upon failure of any bank or financial institution to fund any letter or letters of credit, the commissioner shall proceed to collect same by rule to show cause by applying to the Nineteenth Judicial District Court in and for the parish of East Baton Rouge.

G. In the liquidation or windup of the affairs of the health maintenance organization, notwithstanding any provision of law to the contrary, the commissioner shall assure any payments authorized by the Department of Insurance and issued prior to any order of liquidation are honored; thereafter, the following schedule of preferences shall be followed:

(1) The commissioner's costs and expenses of administration, including unpaid federal and state employment withholding taxes.

(2) Compensation actually owing to employees other than officers of a health maintenance organization for services rendered within three months prior to the commencement of a proceeding against the health maintenance organization under this Part, but not exceeding two thousand five hundred dollars for such employee, shall be paid prior to the payment of any other debt or claim and in the discretion of the commissioner may be paid as soon as practicable after the proceeding has commenced. However, at all times the commissioner shall reserve such funds as will in his opinion be sufficient for the payment of all claims in Paragraphs (1) through (3) of this Subsection. This priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of such employees.

(3) Claims for covered benefits prior to cancellation that are filed within ninety days of an order of liquidation. The commissioner shall, within one hundred twenty days, present a plan for timely payment of such claims to the court for approval. The Department of Insurance shall not require refiling any claim received for covered benefits or provision of any proof of claim that would otherwise be applicable to non-benefit claims. The maximum amount paid shall not exceed the amount that would be paid under Title XVIII of the Social Security Act, 42 U.S.C. §301 et seq. The department shall establish reasonable amounts for any services or supplies covered under a health policy or contract for which an amount has not been determined under the federal Medicare program.

(4) Claims for unearned premiums or other premium refunds.

(5) All other claims, including claims for covered benefits provided prior to cancellation that are not filed within ninety days of an order of liquidation.

Acts 1986, No. 1065, §1; Acts 1995, No. 1231, §1, eff. Sept. 1, 1995; Acts 2003, No. 1106, §1, eff. Dec. 31, 2003.

§2011. Regulation of agents

The commissioner may, after notice and hearing, promulgate such reasonable rules and regulations as are necessary to provide for the licensing of agents. An agent means a person licensed as a life and health insurance agent in the state of Louisiana who is appointed or employed by a health maintenance organization to engage in solicitation of membership in such organization. It shall not include a person enrolling members on behalf of an employer, union, or other organization to whom a master group contract has been issued.

Acts 1986, No. 1065, §1.

§2012. Examination of health maintenance organization and other parties

A. The commissioner or a member of his staff may make an examination of the affairs of any health maintenance organization as often as it is reasonably necessary for the protection of the interest of the people of this state, but not less frequently than once every three years.

B. The commissioner or a member of his staff shall conduct all examinations in accordance with R.S. 22:1301 through 1316.

Acts 1986, No. 1065, §1; Acts 1995, No. 1231, §1, eff. Sept. 1, 1995.

§2013. Suspension or revocation of certificate of authority

A. The commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization under this Part if he finds that any of the following conditions exist:

(1) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any information submitted under R.S. 22:2004, unless the health maintenance organization filed with the commissioner those modifications as required by R.S. 22:2004(D).

(2) The health maintenance organization does not provide or arrange for basic health care services.

(3) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(4) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.

(5) The continued operation of the health maintenance organization would be hazardous to its enrollees.

(6) The health maintenance organization has otherwise failed to substantially comply with this Part.

(7) The health maintenance organization has failed to file or to timely file any of the financial statements as required under this Part.

(8) The health maintenance organization has failed to comply with any requirements of any provision found under this Part.

(9) The health maintenance organization has failed to maintain a statutory deposit as required pursuant to R.S. 22:2010.

B. A certificate of authority shall be suspended or revoked only after compliance with the requirements of R.S. 22:2015 except in cases where such delay would cause irreparable harm or substantial monetary loss in the opinion of the commissioner. In lieu of suspension or revocation of a license duly issued, the commissioner may levy a fine not to exceed one thousand dollars for each violation and up to one hundred thousand dollars aggregate for all violations in a calendar year. The commissioner of insurance is authorized to suspend the imposition of the fines authorized under this Section.

C. When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees, except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

D. When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage without further liability to the enrollee.

E. Where a certificate of authority is revoked or in the liquidation or windup of the affairs of a health maintenance organization, the commissioner shall have the right to enforce, for the benefit of the enrollees, contract performance by any provider or other third party who had contracted with the health maintenance organization.

F. The commissioner is specifically empowered to take over and liquidate the affairs of any health maintenance organization experiencing financial difficulty at such time as he deems it necessary by applying to the Nineteenth Judicial District Court for permission to take over and fix the conditions thereof. The Nineteenth Judicial District Court shall have exclusive jurisdiction over any suit arising from such takeover and liquidation. The commissioner shall be authorized to issue appropriate regulations to implement an orderly procedure to wind up the affairs of any financially troubled health maintenance organization.

G. The commissioner may proceed by summary proceeding and shall not be required to give bond or security.

Acts 1986, No. 1065, §1; Acts 1995, No. 1231, §1, eff. Sept. 1, 1995; Acts 2003, No. 1106, §1, eff. Dec. 31, 2003.

§2014. Regulations

The commissioner may, after notice and hearing, promulgate such rules and regulations, as may be necessary or proper to carry out the provisions of this Part. Such rules and regulations shall be subject to rulemaking and review in accordance with the Administrative Procedure Act.

Acts 1986, No. 1065, §1.

§2015. Administrative procedures

A. When the commissioner has cause to believe that grounds for the denial, suspension, or revocation of an application for a certificate of authority exist, he shall notify the health maintenance organization in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least thirty days thereafter for a hearing on the matter.

B. After such hearing, or upon the failure of the health maintenance organization to appear at such hearing, the commissioner shall take action as he deems advisable and shall issue written findings which shall be sent by certified mail to the health maintenance organization. The action of the commissioner shall be subject to judicial review by the Nineteenth Judicial District Court, which court shall have jurisdiction over any and all legal proceedings arising under this Part. The court may, in disposing of any issue before it, modify, affirm, or reverse the order of the commissioner in whole or in part.

C. The provisions of the Administrative Procedure Act shall apply to hearings and proceedings under this Section to the extent they are not in conflict with Subsection A of this Section.

Acts 1986, No. 1065, §1.

§2016. Statutory construction; relationship to other laws

A. Except as otherwise provided in this Part and in R.S. 22:215.24, provisions of the insurance law and provisions of Part IV of Chapter 1 of this Title shall not be applicable to any health maintenance organization granted a certificate of authority under this Part. This provision shall not apply to an insurer or an entity licensed under the provisions of Part IV of Chapter 1 of this Title except with respect to its health maintenance organization activities authorized and regulated pursuant to this Part.

B. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals, but such health professionals shall be individually subject to the laws, rules, and regulations governing their individual profession.

C. Every health maintenance organization shall make available in writing to its potential enrollees a reasonable explanation of the services to be provided or arranged for. This explanation shall also identify those services excluded from coverage and shall set forth the methods of access to all forms of treatment or class of providers included in the plan.

D. Any health maintenance organization authorized under this Part shall not practice medicine and shall not be deemed to practice medicine, provided however, that the administrative treatment guidelines of the health maintenance organization shall not impinge upon nor encumber the independent medical judgment of the treating physician or health care provider. Nothing in this Subsection shall be construed to prevent a health maintenance organization from conducting a utilization review and quality assurance program.

E. Each health maintenance organization shall meet the following requirements:

(1) All facilities located in this state including but not limited to hospitals, medical facilities, and nursing care and intermediate care facilities to be utilized by the health maintenance organization shall be licensed, if such licensure is required by law.

(2) All personnel employed by or under contract to the health maintenance organization shall be licensed or certified by their respective board or agency, if such licensure or certification is required by law.

(3) All equipment required to be licensed or registered by law shall be so licensed or registered and the operating personnel for such equipment shall be licensed or certified as required by law.

Acts 1986, No. 1065, §1; Acts 2003, No. 190, §1.

§2016.1. Moratorium on additional statutory mandates

A.(1) Notwithstanding any other provision of law to the contrary, a health maintenance organization shall not be required to deliver, issue, or renew a health benefit plan on or after January 1, 2004, and before December 31, 2008, that includes any additional mandate benefit or mandated option beyond those statutory requirements in effect for health maintenance organizations on July 2, 2003.

(2) Nothing in this Section shall be construed to prohibit an employer from electing to expand coverage on any group or individual health benefit plan or policy covering the employer and the employees of the employer.

(3) Nothing in this Section shall be construed to prohibit a health maintenance organization from electing to expand coverage on any group or individual health benefit plan.

B. Nothing in this Section shall affect the fiscal impact report required by R.S. 24:603.1 to be attached to any legislation mandating health insurance benefits or options prior to its consideration by any committee of either house of the legislature.

C. Nothing in this Section shall be construed to allow a health maintenance organization policy delivered, issued, or renewed after July 2, 2003, to suspend, limit, or modify any mandates in effect on that date.

Acts 2003, No. 1115, §1, eff. July 2, 2003.

NOTE: See Acts 2003, Nos. 816 and 829, §§2 and 3.

§2017. Technical advice, advisors, and other technical services

A. The commissioner or the secretary may at any time call upon any other state agency, to serve as an advisor on technical or health care matters and for such technical data, statistics, or other information as he may from time to time require in the administration and enforcement of this Part.

B. In the event it is necessary for the commissioner or secretary to invoke or defend any legal proceedings arising hereunder or with respect hereto, the attorney general of the state shall serve as legal counsel of record for the commissioner or secretary.

C. No later than December 31, 1997, every health maintenance organization which has been licensed under this Chapter shall submit to the commissioner a plan for accreditation under an organization or entity recognized by the commissioner. The commissioner shall be authorized to make an inspection no less frequently than once every three years of each health maintenance organization, which has not been accredited by an organization or entity recognized by the commissioner, to determine whether it is adhering to the minimum standards for utilization review and grievances. The commissioner shall be authorized to establish agreements with the secretary for review of such health maintenance organization's contractual providers and the quality of services it offers and provides to its enrollees. Within thirty days after inspection, the secretary shall transmit a report of such inspection to the governor with a copy thereof transmitted to the commissioner. The costs of all such inspections shall be assessed as regulatory costs by the commissioner.

Acts 1986, No. 1065, §1; Acts 1997, No. 238, §1, eff. June 16, 1997.

§2018. Requirements of provider contracts; prohibited incentives; definitions

A. Every contract between a health maintenance organization and a provider of health care services shall be in writing, and shall set forth:

(1) That in the event the health maintenance organization fails to pay for covered health care services as set forth in the evidence of coverage, the subscriber or enrollee shall not be liable to the provider for any sums owed by the health maintenance organization.

(2) The methodology by which payment will be made.

(3) The procedure for processing and resolving grievances as required under R.S. 22:2022. Such information shall include the location and telephone number where grievances may be submitted.

B. In the event that the contract has not been reduced to writing as required by this Section or that the contract fails to contain the required prohibition, the contracting provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization.

C. No contracting provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

D.(1) A health care provider that does not contract with a health maintenance organization may pursue collection from a health maintenance organization for emergency services rendered, provided that the health care provider has no direct knowledge or information that a patient is an enrollee of a health maintenance organization. The health care provider shall only collect:

(a) From the health maintenance organization the amount paid to participating providers for the same services.

(b) From the patient, subscriber, or enrollee the difference, if any, between the amount charged for such services and the amount received from the health maintenance organization.

(2) An anesthesiologist, pathologist, or a radiologist who is not a participating provider but who provides health care services at a facility that contracts with a health maintenance organization may pursue collection from the health maintenance organization for health care services rendered provided that the anesthesiologist, pathologist, or radiologist has no direct knowledge or information that a patient is an enrollee of the health maintenance organization. The provider shall only collect:

(a) From the health maintenance organization the amount paid to participating providers for the same services.

(b) From the patient, subscriber, or enrollee the difference, if any, between the amount charged for such services and the amount received from the health maintenance organization.

E. A health maintenance organization, managed care organization, or their contracting entities shall not include provisions in their contracts with health care providers which include an incentive or specific payment made directly, in any form, to a health care provider or health care provider group as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services provided with respect to a specific insured or groups of insureds with similar medical conditions.

F. Nothing in this Section shall be construed to prohibit contracts that contain incentive plans that involve general payments, such as capitation payments, or shared-risk arrangements that are not tied to specific medical decisions involving a specific insured or groups of insureds with similar medical conditions. The payments rendered or to be rendered to physicians, physician groups, or other licensed health care practitioners under these arrangements shall be deemed confidential information.

G. As used in Subsections E and F of this Section, the following definitions shall apply:

(1) "Managed care organization" means a licensed insurance company, hospital, or medical benefit plan or program, health maintenance organization, integrated health care delivery system, an employer or employee organization, or a managed care contractor which operates a managed care plan. A managed care entity may include but it is not limited to a preferred provider organization, health maintenance organization, exclusive provider organization, independent practice association, clinic without walls, management services organization, managed care services organization, physician hospital organization, and hospital physician organization.

(2) "Managed care plan" means a plan operated by a managed care organization which provides for the financing and delivery of health care and treatment services to individuals enrolled in such plan through its own employed health care providers or contracting with selected specific providers that conform to explicit selection, standards, or both. A managed care plan shall also mean a plan that has a formal organizational structure for continual quality assurance, a certified utilization review program, dispute resolution, and financial incentives for individual enrollees to use the plan's participating providers and procedures.

Acts 1986, No. 1065, §1; Acts 1995, No. 1159, §1; Acts 1997, No. 238, §1, eff. June 16, 1997; Acts 1997, No. 897, §1.

§2019. Restriction on alienations or transfers of certificate of authority

A certificate of authority shall not be disposed of, sold, transferred, or utilized by any person other than the applicant except as authorized by the commissioner in a proceeding for such purpose. The provisions of the Administrative Procedure Act shall apply to proceedings under this Section.

Acts 1986, No. 1065, §1.

§2020. Confidentiality of medical information

A. Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or potential enrollee obtained from such persons or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except:

(1) To the extent that it may be necessary to carry out the purposes of this Part or as otherwise permitted by law.

(2) Upon the express consent of the enrollee or potential enrollee.

(3) Pursuant to statute or court order for the production of evidence or the discovery thereof.

(4) In the event of a claim or litigation between such person and the health maintenance organization, wherein such data or information is pertinent.

B. A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled.

Acts 1986, No. 1065, §1.

§2021. Medical necessity review

Every health maintenance organization shall assure full compliance with Chapter 7 of this Title in establishing procedures for continuous review of quality of care, performance of providers, utilization of health services, facilities, and costs. The medical necessity review requirements and administrative treatment guidelines of the health maintenance organization shall not fall below the appropriate standard of care and shall not impinge upon the independent medical judgment of the treating health care provider. Nothing in this Section shall be construed to prevent a health maintenance organization from conducting a medical necessity review and quality assurance program.

Acts 1986, No. 1065, §1; Acts 1997, No. 238, §1, eff. June 16, 1997; Acts 1997, No. 1324, §1; Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

§2022. Enrollee grievance procedure

A. Every health maintenance organization shall establish and maintain a grievance system approved by the commissioner under which enrollees may submit their grievances to the health maintenance organization. Each system shall provide reasonable procedures which shall insure adequate consideration of enrollee grievances and rectification when appropriate.

B. Every health maintenance organization shall inform its subscribers and enrollees upon enrollment in the health maintenance organization and annually thereafter of the procedure for processing and resolving grievances. Such information shall include the location and telephone number where grievances may be submitted.

C. The health maintenance organization shall keep in its files all copies of complaints, and the responses thereto, for a period of five years.

D. The commissioner, in compliance with the Louisiana Administrative Procedure Act, shall be authorized to issue such rules, regulations, and orders as shall be necessary to implement procedures that assure that plan members and participating providers have the opportunity for the appropriate resolution of their grievances. Accreditation by a nationally recognized accrediting body or entity recognized by the commissioner shall be evidence of meeting the requirements of this Section.

Acts 1986, No. 1065, §1; Acts 1997, No. 238, §1, eff. June 16, 1997.

§2023. Reports to the governor

The secretary and the commissioner each shall report annually to the governor on the activities of his office with respect to health maintenance organizations and shall make such suggestions for change or improvement as may be in the best interest of the state and the industry.

Acts 1986, No. 1065, §1.

§2024. Fees

A. The following fees shall be collected in advance by the secretary of state for health maintenance organization:

(1)For filing a charter, other documents, and amendments thereto, per page	$ 2.50
(2)For certified copies of any document, per page	$ 2.00

B. The following fees and licenses shall be collected in advance by the commissioner of insurance for health maintenance organizations:

(1)		Certificates of authority	$ 500.00
(2)		For filing a charter, other documents and amendments	5.00
(3)	(a)	For filing annual statement	250.00
	(b)	Penalty for unauthorized late filing	1,000.00
(4)		Initial examination of health maintenance organization companies	1,000.00
(5)		For certified copies of any documents, per page	3.00
(6), (7)		REPEALED BY ACTS 1996, 1st Ex. Sess., No. 71, §2, eff. May 10, 1996.	
(8)		The commissioner may assess additional regulatory fees due to costs incurred by the Louisiana Department of Insurance.	

Acts 1986, No. 1065, §1; Acts 1996, 1st Ex. Sess., No. 71, §2, eff. May 10, 1996; Acts 2001, No. 161, §1.

§2025. Taxes and tax base

A. In lieu of the state income tax and the corporate franchise tax levied in Title 47 of the Louisiana Revised Statutes of 1950, every health maintenance organization authorized and certified to engage in the business of issuing contracts or other evidences or similar forms of coverage to enrollees for health care services or prepaid medical services in this state, including Louisiana partnerships authorized under R.S. 22:2004(B), shall pay an annual license tax for the year 1986, and each subsequent year, on the gross amount of its receipts from contracts and other evidences of coverage at the same rate as the license tax on life insurance companies provided in R.S. 22:1062 and R.S. 22:1067.

B. The license taxes levied under this Section shall be paid to the commissioner at Baton Rouge and shall be remitted on a quarterly basis by the same procedure as established under R.S. 22:1071. The tax payment shall be accompanied by a license tax form supplied by the commissioner and completed in full by the health maintenance organizations. Nothing contained herein shall be construed as relieving any insurer from paying to the commissioner the fees otherwise required for qualifying to do business, or for the renewal thereof.

C. Taxes due hereunder shall be paid in advance based on writings of the previous calendar year computed on the same base as provided for in R.S. 22:1066.

D. The tax credit provided pursuant to R.S. 22:1068 shall apply the same for health maintenance organizations as for insurance companies.

E. The provisions of R.S. 22:1072 shall apply in the event a health maintenance organization fails to pay a license tax required by this Section.

F. The commissioner of insurance shall follow the provisions of R.S. 22:1075 regarding the maintenance of books and records and the disposition of collections.

Acts 1986, No. 1065, §1.

§2026. Enrollment application; required statement; annual notification and disclosure of information

A. Every application for enrollment in a health maintenance organization shall contain the following statement conspicuously displayed on the front of such application in at least ten point bold-face capital letters: **"NOTICE - YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN."**

B. The commissioner shall assess a penalty if he determines that a health maintenance organization's enrollment application or annual notices do not contain the language required in this Section. Any insurer violation of this Section shall be considered an unfair trade practice and subject to the penalties provided for under R.S. 22:1217.

C. Every subscriber and enrollee shall at the time of enrollment and annually thereafter be provided with a written notice which fully explains copayment and deduction amounts applicable to each covered service. Any separate deductible amounts shall be fully disclosed. The written notice shall be printed in ten-point or larger type and shall outline any limitations on the choice of primary care physicians, access to specialists, and application of preexisting medical condition exclusions from coverage.

D. Every subscriber, enrollee, and participating provider shall be provided with an annual plan notification statement which provides:

(1) A listing of compensation mechanisms utilized to pay providers including incentive arrangements.
(2) A description of the services or treatments which will be covered under the plan.
(3) A statement regarding the coverage of experimental treatments.
(4) A statement regarding the coverage of prescription drugs. Such statement shall include the procedure used for adding or deleting coverage of specific prescribed drugs.

Acts 1989, No. 695, §1, eff. Jan 1, 1990; Acts 1997, No. 238, §1, eff. June 16, 1997.

§2027. Notice required for certain prepaid charge rate increases, cancellation or nonrenewal of service agreements; other requirements

A.(1) Every health maintenance organization regulated by this Part shall notify each master contract group in writing at least forty-five days before any increase of twenty percent or more in prepaid charges or at least sixty days before any cancellation or nonrenewal of an agreement for basic health care services.

(2) The notice required by Paragraph (1) of this Subsection may be waived for a basic health care service agreement which covers one hundred or more persons, provided a provision for such waiver is made part of the basic health care services agreement agreed upon by the insurer and the holder of the master contract.

B. Nothing in this Section shall be construed to grant to the health maintenance organization any additional authorization in relation to cancellation, nonrenewal, or other termination of an agreement for basic health care services and all provisions of this Part which regulate such events shall apply. No basic health care services agreement shall be cancelled, nonrenewed, or otherwise terminated because the health maintenance organization failed to meet the notice provisions of this Section.

C. The notice provisions of this Section shall not apply to cancellations due to nonpayment on a timely basis of the prepaid charges.

D.(1)(a) Every health maintenance organization authorized under this Part may include in its plan obstetricians or gynecologists as primary care physicians. In addition, the health maintenance organization shall not limit direct access to an in-network obstetrician or gynecologist for routine gynecological care. This selection shall be permitted without penalty or denial of the benefits provided under the health maintenance organization.

(b) Routine gynecological care as used in this Section shall mean a minimum of two routine annual visits, provided that the second visit shall be permitted based upon medical need only, and follow-up treatment within sixty days following either visit if related to a condition diagnosed or treated during the visits, and any care related to a pregnancy. Nothing in this Section shall prevent a policy, program, or plan from requiring that an obstetrician-gynecologist treating a covered patient coordinate that care with the patient's primary care physician, if applicable, or in conjunction with other oversight procedures.

(2) Any provision in a health maintenance organization plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state which is contrary to this Section shall, to the extent of such conflict, be void.

E.(1) Every health maintenance organization regulated by this Part which provides coverage for mastectomy surgery shall provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. The coverage required by this Section shall be subject to the reconstructive surgery or surgeries which are part of the treatment plan agreed to by the patient and the attending physician. The coverage for the reconstructive surgery shall only be required if the reconstructive surgery is performed under the same policy or plan under which the mastectomy was performed. This coverage shall be subject to the same deductible, co-insurance, and copayment provisions applicable to the coverage for mastectomy surgery.

(2) The provisions of this Subsection shall not apply to individually underwritten limited benefit and supplemental health insurance policies.

F. Every health maintenance organization authorized under this Part shall also be subject to the requirements of Part VI-D of Chapter 1 of this Title.

Acts 1990, No. 538, §1; Acts 1995, No. 637, §1; Acts 1997, No. 1313, §1; Acts 1997, No. 1341, §1; Acts 1999, No. 1017, §1, eff. July 9, 1999.

PART XII-A. DENTAL REFERRAL PLANS

§2028. Purpose

The purpose of this Part shall be to protect the public from inappropriate, unfair, and deceptive practices and to promote the public's access to high quality, cost-effective dental care through the registration of dental referral plans.

Acts 1995, No. 1050, §1.

§2029. Definitions

As used in this Part, the following terms shall have the following meaning ascribed to them in this Section unless the context clearly indicates otherwise:

(1) A "dental referral plan" shall be defined as a contractual plan that provides a list of dental care providers who have agreed to render treatment to enrollees at specific discounted fees. The plans may collect fees from enrollees, employers, insurers, or health maintenance organizations. The plans shall not be deemed insurance, except as otherwise indicated by law.

(2) An "enrollee" shall be defined as an individual, including eligible dependents, entitled to receive a list of participating dental care providers and to be treated at discounted fees.

(3) A "dental care provider" shall be defined as an individual who is a dentist who has contracted with the dental referral plan to deliver certain dental care services to an enrollee at a reduced fee.

Acts 1995, No. 1050, §1; Acts 1997, No. 1125, §1; Acts 1997, No. 1439, §1, eff. July 15, 1997.

§2030. Registration

No dental referral plan shall conduct business or otherwise operate in this state unless it is registered with the commissioner of insurance as hereinafter provided.

Acts 1995, No. 1050, §1.

§2031. Procedure for registration

A. An applicant for registration shall:

(1) Submit an application to the commissioner.

(2) Pay the application fee established by this Part.

B. The application shall be on a form and accompanied by any supporting documentation required by the commissioner and shall be signed and verified by the applicant. The information required by the application shall include but need not be limited to the following:

(1) The name of the entity operating the dental referral plan and any trade or business names used by that entity in connection with the operation of the dental referral plan.

(2) The names and addresses of every officer and director of the entity operating the dental referral plan as well as the name and address of the corporate officer designated by the plan as the corporate representative to receive, review, and resolve all grievances addressed to the plan.

(3) The name and address of every person owning, directly or indirectly, five percent or more of the entity operating the dental referral plan.

(4) The principal place of business of the dental referral plan.

(5) A general description of the operation of the dental referral plan which includes a statement that the plan does not provide indemnity insurance coverage for dental services.

(6) A sample copy of a contract with an enrollee which includes a general description of enrollee's rights under the dental referral plan.

(7) A sample copy of a contract, absent fee schedule, with a provider which includes a general description of dental care provider's rights under the dental referral plan.

Acts 1995, No. 1050, §1.

§2032. Expiration and renewal of registration

A. Registration pursuant to this Part shall expire on August 15, 1997, unless the registration is renewed for a two-year term as provided in this Section.

B. Before the registration expires, it may be renewed for an additional two-year term if the applicant:

(1) Pays a renewal fee as provided in this Part.

(2) Submits to the commissioner a renewal application on the form that the commissioner requires.

C. The renewal application required by the commissioner shall require but not be limited to the information required for an initial application.

Acts 1995, No. 1050, §1.

§2033. Rules and fees

Fees for initial and renewal application shall be two hundred fifty dollars.

Acts 1995, No. 1050, §1.

§2034. Penalties

A. Any dental referral plan which is found, after notice and hearing by an administrative law judge pursuant to Chapter 13-B of Title 49 of the Louisiana Revised Statutes of 1950, to have violated any provision of this Part, may be subject to a penalty under this Section.

B. A monetary penalty not to exceed two thousand five hundred dollars may be imposed for each violation.

C. Nothing contained in this Section shall affect the authority of the department to impose any other penalties provided for in this Title, or rule, regulation, or order promulgated thereunder.

Acts 2003, No. 282, §1, eff. June 10, 2003.

§2035. [Blank]

PART XII-B. RISK-BASED CAPITAL REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS

§2036. [Blank]

§2036.1. Definitions

As used in this Part, these terms shall have the following meanings:

(1) "Adjusted risk-based capital report" means a risk-based capital report which has been adjusted by the commissioner in accordance with R.S. 22:2036.2(C).

(2) "Commissioner" means the commissioner of insurance.

(3) "Corrective order" means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required.

(4) "Health organization" means a health maintenance organization licensed under Part XII of Chapter 2 of this Title.

(5) "Risk-based capital instructions" means the risk-based capital report including risk-based capital instructions adopted by the National Association of Insurance Commissioners, as these risk-based capital instructions may be amended by the National Association of Insurance Commissioners from time to time in accordance with the procedures adopted by the National Association of Insurance Commissioners.

(6) "Risk-based capital level" means a health organization's company action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital, or mandatory control level risk-based capital where:

(a) Effective December 31, 2003:

(i) "Company action level risk-based capital" means the product of 1.5 and the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

(ii) "Regulatory action level risk-based capital" means the product of 1.25 and the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

(iii) "Authorized control level risk-based capital" means the product of 1.1 and the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

(iv) "Mandatory control level risk-based capital" means the product of .95 and the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

(b) Effective December 31, 2004:

(i) "Company action level risk-based capital" means the product of 2.0 and the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

(ii) "Regulatory action level risk-based capital" means the product of 1.5 and the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

(iii) "Authorized control level risk-based capital" means the product of 1.25 and the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

(iv) "Mandatory control level risk-based capital" means the product of .95 and the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

(7) "Risk-based capital plan" means a comprehensive financial plan containing the elements specified in R.S. 22:2036.4(B). If the commissioner rejects the risk-based capital plan and it is revised by the health organization, with or without the commissioner's recommendation, the plan shall be called the "revised risk-based capital plan".

(8) "Risk-based capital report" means the report required in R.S. 22:2036.2.

(9) "Total adjusted capital" means the sum of the following:

(a) A health organization's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under R.S. 22:2008.

(b) Such other items, if any, as the risk-based capital instructions may provide.

Acts 2003, No. 1106, §1, eff. Dec. 31, 2003.

§2036.2. Risk-based capital reports

A. A health organization shall, on or prior to each March first, prepare and submit to the commissioner a report of its risk-based capital levels as of the end of the calendar year just ended, in a form and containing such information as is required by the risk-based capital instructions. In addition, a health organization shall file its risk-based capital report with the National Association of Insurance Commissioners in accordance with the risk-based capital instructions.

B. A health organization's risk-based capital shall be determined in accordance with the formula set forth in the risk-based capital instructions. The formula shall take the following into account and may adjust for the covariance between the factors as determined in each case by applying the factors in the manner set forth in the risk-based capital instructions:

(1) Asset risk.

(2) Credit risk.

(3) Underwriting risk.

(4) All other business risks and such other relevant risks as are set forth in the risk-based capital instructions.

C. If a health organization files a risk-based capital report that in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the risk-based capital report to correct the inaccuracy and shall notify the health organization of the adjustment. The notice shall contain a statement of the reason for the adjustment. A risk-based capital report as so adjusted may be referred to as an adjusted risk-based capital report.

Acts 2003, No. 1106, §1, eff. Dec. 31, 2003.

§2036.3. Supplemental quarterly reports of risk-based capital

A health organization shall submit to the Department of Insurance each quarter, as a standard quarterly filing, a report on additional key financial data, pursuant to a regulation promulgated by the department for this purpose. The health organization shall submit this report no later than forty-five days of the end of the quarter unless an extension, not to exceed thirty days, is granted by the department based on circumstances that are reasonably beyond the health organization's control.

Acts 2003, No. 1106, §1, eff. Dec. 31, 2003.

§2036.4. Company action level event

A. A "company action level event" means any of the following:

(1) The filing of a risk-based capital report by a health organization that indicates that the health organization's total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based capital.

(2) Notification by the commissioner to the health organization of an adjusted risk-based capital report that indicates an event in Paragraph (1) of this Subsection, provided the health organization does not challenge the adjusted risk-based capital report under R.S. 22:2036.8.

(3) If pursuant to R.S. 22:2036.8, a health organization challenges an adjusted risk-based capital report that indicates the event in Paragraph (1) of this Subsection, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

B. In the event of a company action level event, the health organization shall prepare and submit to the commissioner a risk-based capital plan that shall do the following:

(1) Identify the conditions that contribute to the company action level event.

(2) Contain proposals of corrective actions that the health organization intends to take and that would be expected to result in the elimination of the company action level event.

(3) Provide projections of the health organization's financial results in the current year and at least the two succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and risk-based capital levels. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense, and benefit component.

(4) Identify the key assumptions impacting the health organization's projections and the sensitivity of the projections to the assumptions.

(5) Identify the quality of and problems associated with the health organization's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

C. The risk-based capital plan shall be submitted either:

(1) Within forty-five days of the company action level event.

(2) If the health organization challenges an adjusted risk-based capital report pursuant to R.S. 22:2036.8, within forty-five days after notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

D. Within sixty days after the submission by a health organization of a risk-based capital plan to the commissioner, the commissioner shall notify the health organization whether the risk-based capital plan shall be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the risk-based capital plan is unsatisfactory, the notification to the health organization shall set forth the reasons for the determination and may set forth proposed revisions which will render the risk-based capital plan satisfactory, in the judgment of the commissioner. Upon notification from the commissioner, the health organization shall prepare a revised risk-based capital plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised risk-based capital plan to the commissioner either:

(1) Within forty-five days after the notification from the commissioner.

(2) If the health organization challenges the notification from the commissioner pursuant to R.S. 22:2036.8, within forty-five days after a notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

E. In the event of a notification by the commissioner to a health organization that the health organization's risk-based capital plan or revised risk-based capital plan is unsatisfactory, the commissioner may at the commissioner's discretion, subject to the health organization's right to a hearing under R.S. 22:2036.8, specify in the notification that the notification constitutes a regulatory action level event.

Acts 2003, No. 1106, §1, eff. Dec. 31, 2003.

§2036.5. Regulatory action level event

A. "Regulatory action level event" means any of the following events:

(1) The filing of a risk-based capital report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its authorized control level risk-based capital but less than its regulatory action level risk-based capital.

(2) Notification by the commissioner to a health organization of an adjusted risk-based capital report that indicates the event in Paragraph (1) of this Subsection, provided the health organization does not challenge the adjusted risk-based capital report under R.S. 22:2036.8.

(3) If, pursuant to R.S. 22:2036.8, the health organization challenges an adjusted risk-based capital report that indicates the event in Paragraph (1) of this Subsection, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

(4) The failure of the health organization to file a risk-based capital report by the filing date, unless the health organization has provided an explanation for the failure that is satisfactory to the commissioner and has cured the failure within ten days after the filing date.

(5) The failure of the health organization to submit a risk-based capital plan to the commissioner within the time period set forth in R.S. 22:2036.4(C).

(6) Notification by the commissioner to the health organization that both of the following apply:

(a) The risk-based capital plan or revised risk-based capital plan submitted by the health organization is, in the judgment of the commissioner, unsatisfactory.

(b) Notification constitutes a regulatory action level event with respect to the health organization, provided the health organization has not challenged the determination pursuant to R.S. 22:2036.8.

(7) If, pursuant to R.S. 22:2036.8, the health organization challenges a determination by the commissioner pursuant to Paragraph (6) of this Subsection, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the challenge.

(8) Notification by the commissioner to the health organization that the health organization has failed to adhere to its risk-based capital plan or revised risk-based capital plan, but only if the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event in accordance with its risk-based capital plan or revised risk-based capital plan and the commissioner has so stated in the notification, provided the health organization has not challenged the determination under R.S. 22:2036.8.

(9) If, pursuant to R.S. 22:2036.8, the health organization challenges a determination by the commissioner under Paragraph (8) of this Subsection, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the challenge.

B. In the event of a regulatory action level event the commissioner shall do the following:

(1) Require the health organization to prepare and submit a risk-based capital plan or, if applicable, a revised risk-based capital plan.

(2) Perform such examination or analysis as the commissioner deems necessary of the assets, liabilities, and operations of the health organization including a review of its risk-based capital plan or revised risk-based capital plan.

(3) Subsequent to the examination or analysis, issue an order specifying such corrective actions as the commissioner shall determine are required.

C. In determining corrective actions, the commissioner may take into account factors the commissioner deems relevant with respect to the health organization based upon the commissioner's examination or analysis of the assets, liabilities, and operations of the health organization, including but not limited to the results of any sensitivity tests undertaken pursuant to the risk-based capital instructions. The risk-based capital plan or revised risk-based capital plan shall be submitted either:

(1) Within forty-five days after the occurrence of the regulatory action level event.

(2) If the health organization challenges an adjusted risk-based capital report pursuant to R.S. 22:2036.8 and the challenge is not frivolous in the judgment of the commissioner, within forty-five days after the notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

(3) If the health organization challenges a revised risk-based capital plan pursuant to R.S. 22:2036.8 and the challenge is not frivolous in the judgment of the commissioner, within forty-five days after the notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

D. The commissioner may retain actuaries, investment experts, and other consultants as may be necessary in the judgment of the commissioner to review the health organization's risk-based capital plan or revised risk-based capital plan, examine or analyze the assets, liabilities, and operations, including contractual relationships of the health organization, and formulate the corrective order with respect to the health organization. The fees, costs, and expenses relating to such consultants shall be borne by the affected health organization or such other party as directed by the commissioner.

Acts 2003, No. 1106, §1, eff. Dec. 31, 2003.

§2036.6. Authorized control level event

A. "Authorized control level event" means any of the following events:

(1) The filing of a risk-based capital report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its mandatory control level risk-based capital but less than its authorized control level risk-based capital.

(2) The notification by the commissioner to the health organization of an adjusted risk-based capital report that indicates the event in Paragraph (1) of this Subsection, provided the health organization does not challenge the adjusted risk-based capital report pursuant to R.S. 22:2036.8.

(3) If, pursuant to R.S. 22:2036.8, the health organization challenges an adjusted risk-based capital report that indicates the event in Paragraph (1) of this Subsection, notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

(4) The failure of the health organization to respond, in a manner satisfactory to the commissioner, to a corrective order, provided the health organization has not challenged the corrective order pursuant to R.S. 22:2036.8.

(5) If the health organization has challenged a corrective order pursuant to R.S. 22:2036.8 and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the health organization to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

B. In the event of an authorized control level event with respect to a health organization, the commissioner shall do either of the following:

(1) Take such actions as are required under R.S. 22:2036.5 regarding a health organization with respect to which a regulatory action level event has occurred.

(2) If the commissioner deems it to be in the best interests of the policyholders and creditors of the health organization and of the public, take such actions as are necessary to cause the health organization to be placed under regulatory control pursuant to Part XVI of Chapter 1 of this Title. In the event the commissioner takes such actions, the authorized control level event shall be deemed sufficient grounds for the commissioner to take action pursuant to Part XVI of Chapter 1 of this Title and the commissioner shall have the rights, powers, and duties with respect to the health organization as are set forth in Part XVI of Chapter 1 of this Title.

Acts 2003, No. 1106, §1, eff. Dec. 31, 2003.

§2036.7. Mandatory control level event

A. "Mandatory control level event" means any of the following events:

(1) The filing of a risk-based capital report which indicates that the health organization's total adjusted capital is less than its mandatory control level risk-based capital.

(2) Notification by the commissioner to the health organization of an adjusted risk-based capital report that indicates the event in Paragraph (1) of this Subsection, provided the health organization does not challenge the adjusted risk-based capital report pursuant to R.S. 22:2036.8.

(3) If, pursuant to R.S. 22:2036.8, the health organization challenges an adjusted risk-based capital report that indicates the event in Paragraph (1) of this Subsection, notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

B. In the event of a mandatory control level event, the commissioner shall take such actions as are necessary to place the health organization under regulatory control pursuant to Part XVI of Chapter 1 of this Title. In that event, the mandatory control level event shall be deemed sufficient grounds for the commissioner to take action under, and the commissioner shall have the rights, powers, and duties with respect to the health organization as are set forth in Part XVI of Chapter 1 of this Title. Notwithstanding any of the foregoing, the commissioner may forego action for up to ninety days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period.

Acts 2003, No. 1106, §1, eff. Dec. 31, 2003.

§2036.8. Hearings

Upon the occurrence of any of the following events, the health organization shall have the right to a confidential departmental hearing, on a record, at which the health organization may challenge any determination or action by the commissioner. The health organization shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under Paragraph (1), (2), (3), or (4) of this Section. Upon receipt of the health organization's request for a hearing, the commissioner shall set a date for the hearing, which shall be no less than ten nor more than thirty days after the date of the health organization's request. The events include:

(1) Notification to a health organization by the commissioner of an adjusted risk-based capital report.

(2) Notification to a health organization by the commissioner that both of the following apply:

(a) The health organization's risk-based capital plan or revised risk-based capital plan is unsatisfactory.

(b) Notification constitutes a regulatory action level event with respect to the health organization.

(3) Notification to a health organization by the commissioner that the health organization has failed to adhere to its risk-based capital plan or revised risk-based capital plan and that the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event with respect to the health organization in accordance with its risk-based capital plan or revised risk-based capital plan.

(4) Notification to a health organization by the commissioner of a corrective order with respect to the health organization.

Acts 2003, No. 1106, §1, eff. Dec. 31, 2003.

§2036.9. Confidentiality; prohibition on announcements; prohibition on use in ratemaking

A. All risk-based capital reports, to the extent the information is not required to be set forth in a publicly available annual statement schedule, and risk-based capital plans, including the results or report of any examination or analysis of a health organization performed pursuant to this Part and any corrective order issued by the commissioner pursuant to examination or analysis, with respect to a domestic health organization or foreign health organization that are in the possession or control of the Department of Insurance shall be confidential by law and privileged, shall not be subject to Chapter 1 of Title 44 of the Louisiana Revised Statutes of 1950, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

B. Neither the commissioner nor any person who received documents, materials, or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to Subsection A of this Section.

C. In order to assist in the performance of the commissioner's duties, the commissioner may do any of the following:

(1) Share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to Subsection A of this Section, with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information.

(2) Receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(3) Enter into agreements governing sharing and use of information consistent with this Subsection.

D. No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this Section or as a result of sharing as authorized in Paragraph (3) of Subsection C of this Section.

E. It is the judgment of the legislature that the comparison of a health organization's total adjusted capital to any of its risk-based capital levels is a regulatory tool which may indicate the need for corrective action with respect to the health organization and is not intended as a means to rank health organizations generally. Therefore, except as otherwise required under the provisions of this Part, the making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over a radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the risk-based capital levels of any health organization, or of any component derived in the calculation, by any health organization, provider, broker, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited. However, if any materially false statement with respect to the comparison regarding a health organization's total adjusted capital to its risk-based capital levels, or any of them, or an inappropriate comparison of any other amount to the health organizations' risk-based capital levels is published in any written publication and the health organization is able to demonstrate to the commissioner with substantial proof the falsity of the statement, or the inappropriateness, as the case may be, then the health organization may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

F. It is the further judgment of the legislature that an excess of capital (i.e., net worth) over the amount produced by the risk-based capital requirements contained in this Part and the formulas, schedules, and instructions referenced in this Part are desirable in the business of health insurance. Accordingly, health organizations should seek to maintain capital above the risk-based capital levels required by this Part. Additional capital is used and useful in the insurance business and helps to secure a health organization against various risks inherent in or affecting the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this Part.

Acts 2003, No. 1106, §1, eff. Dec. 31, 2003.

§2036.10. Supplemental provisions; rules; exemption

A. The provisions of this Part are supplemental to any other provisions of the laws of this state and shall not preclude or limit any other powers or duties of the commissioner under such laws.

B. The commissioner may adopt reasonable rules necessary for the implementation of this Part.

Acts 2003, No. 1106, §1, eff. Dec. 31, 2003.

§2036.11. Immunity

There shall be no liability on the part of and no cause of action shall arise against the commissioner or the Department of Insurance or its employees or agents for any action taken by them in the performance of their powers and duties pursuant to this Part.

Acts 2003, No. 1106, §1, eff. Dec. 31, 2003.

§2036.12. Notices to health maintenance organizations, effectiveness

All notices by the commissioner to a health maintenance organization that may result in regulatory action under this Part shall be effective upon dispatch if transmitted by registered or certified mail or, in the case of any other transmission, shall be effective upon the health maintenance organization's receipt of notice.

Acts 2003, No. 1106, §2, eff. Dec. 31, 2003.

PART XIII. NONPROFIT BENEFICIARY ORGANIZATIONS AND RISK INDEMNIFICATION TRUSTS

§2041. Title; purpose

A. This Part may be cited as the "Nonprofit Risk Indemnification Trust Act."

B. The purpose of this Part is to authorize the establishment of trust funds for the purpose of indemnifying nonprofit beneficiary organizations and their officers, directors, and agents for financial loss due to the imposition of legal liability, and to regulate the operation of trust funds established under this Section.

Acts 1986, No. 574, §2.

§2042. Establishment upon approval of commissioner

No trust fund with the purpose of indemnifying multiple nonprofit beneficiary organizations shall be established without the prior approval of the commissioner of insurance. The commissioner shall withhold approval of any trust fund that fails to comply with the provisions and requirements of this Part.

Acts 1986, No. 574, §2.

§2043. Eligibility

No organization, corporation, agency, or program shall be a beneficiary for any trust fund established hereunder unless it is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code of 1954, as amended through December 30, 1985.

Acts 1986, No. 574, §2.

§2044. Limitation

No trust fund established hereunder shall indemnify any beneficiary for property loss, liabilities incurred under the workers' compensation act, or for benefits provided to employees pursuant to any medical, dental, life, or disability income protection plan.

Acts 1986, No. 574, §2.

§2045. Bylaws and plan of operation benefits

Every trust fund shall establish in its bylaws and plan of operation a schedule of benefits, to be approved by the commissioner, governing the indemnification of beneficiaries of the trust. The schedule of benefits shall include all conditions, limitations, and exclusions relevant to indemnification.

Acts 1986, No. 574, §2.

§2046. Written indemnification agreement

Every trust fund established under this Part shall provide each of its beneficiaries with a written indemnification agreement specifying the rights and obligations of the trust fund and the beneficiary under the agreement. Each form of indemnification agreement shall be filed with and approved by the commissioner.

Acts 1986, No. 574, §2.

§2047. Contributions to fund operations

The trust fund shall establish contributions required of beneficiaries necessary to fund the operations of the fund. All contribution schedules shall be filed with and approved by the commissioner prior to use. Contributions shall be based on sound actuarial principles and be adequate to fund the operation of the trust fund. Contributions may not be excessive in relation to the benefits provided or be unfairly discriminatory.

Acts 1986, No. 574, §2.

§2048. Pooling prohibited

No trust fund shall enter into an agreement with any other trust fund whereby the risks assumed by each are pooled or shared.

Acts 1986, No. 574, §2.

§2049. Board of trustees; terms; removal; meetings; salary

(A) Every trust fund shall be governed by a board of no fewer than five trustees. The initial trustees need not be appointed or elected by the beneficiaries of the trust fund. During the second year following the creation of an authorized trust fund, at least one-fourth of all its trustees in office shall have been elected or appointed by the beneficiaries. After the end of the second year following the creation of an authorized trust fund, a majority of all trustees in office shall have been elected or appointed by the beneficiaries.

(B) All trustees serving during the first two years following the creation of an authorized trust fund shall be elected or appointed for one-year terms. All trustees serving thereafter shall be elected or appointed for two-year terms, provided that the trustees may be elected or appointed for one-year terms to the extent necessary in order to create staggered terms.

(C) Any trustee may be removed at any time, with or without cause, by a majority vote of the beneficiaries.

(D) The board of trustees shall meet no fewer than four times each year.

(E) No trustee shall be paid a salary or receive other compensation for service as a trustee, except that the bylaws or plan of operation may provide for reimbursement for actual expenses incurred on behalf of the trust fund and for the payment of a reasonable per diem amount for attendance at meetings of the board.

Acts 1986, No. 574, §2.

§2050. Trustees bylaws and plan of operation

The trustees of each trust fund authorized shall cause to be adopted a set of bylaws and plan of operation which shall govern the operation of the trust fund. All bylaws and plans of operation or amendments to them are subject to prior approval by the commissioner. The commissioner shall adopt rules governing the content and approval of bylaws or plans of operation.

Acts 1986, No. 574, §2.

§2051. Annual reported financial statement

Every authorized trust fund shall, by June first of every year, file with the commissioner a financial statement for the previous year's operations. The financial statement shall include the opinion of a licensed certified public accountant that the statement was prepared in conformity with generally accepted accounting principles. Also by June first of every year, every trust fund shall file with the commissioner, on forms provided by the department, a report summarizing the trust fund's operations during the previous year.

Acts 1986, No. 574, §2.

§2052. Assets

Every authorized trust fund shall have and maintain financial assets sufficient to satisfy all current and future financial obligations and responsibilities to beneficiaries. The commissioner shall adopt rules establishing minimum financial standards for authorized trust funds.

Acts 1986, No. 574, §2.

§2053. Contracts with risk managements service providers

Authorized trust funds may enter into contracts with risk management service providers, actuarial consultants, or other vendors as are necessary to ensure the effective and efficient operation of trust fund. Fees paid to vendors for services provided shall not be excessive.

Acts 1986, No. 574, §2.

§2054. Coinsurance and reinsurance

Authorized trust funds may insure or reinsure their obligations and liabilities with insurance companies authorized to do business in Louisiana or with companies similarly authorized in any other state of the United States.

Acts 1986, No. 574, §2.

§2055. Cause of action restricted

No beneficiary shall have any cause of action against any other beneficiary arising solely out of the insolvency or inability of the trust fund to meet its obligations.

Acts 1986, No. 574, §2.

§2056. Commissioner's authority to examine

The commissioner may examine authorized trust funds to the same extent and with the same purpose as is provided, with respect to insurance companies.

Acts 1986, No. 574, §2.

§2057. Deposit

As a condition of authorization, every trust fund shall deposit with the commissioner security of cash, bonds, or evidences of deposit in a licensed insured financial institution of a value equal to five hundred thousand dollars. In the event that a trust fund fails to honor the obligations assumed by it under trust agreements issued to its beneficiaries, use of the security deposit shall revert to the commissioner for the purpose of executing the trust fund's obligations to its beneficiaries on a pro rata basis. The commissioner may adopt rules governing the manner of the amount of security required and the acceptable forms of security.

Acts 1986, No. 574, §2.

§2058. Administrative rules

The commissioner may adopt rules to enforce and administer the requirements of this Part, according to the provisions of the Administrative Procedure Act.

Acts 1986, No. 574, §2.

§2059. Trust funds not insurance

A trust fund established under this Part shall not be considered an insurance company or to be in the business of insurance, nor shall it be subject to regulation by the commissioner, except as provided for in this Part and in R.S. 22:215.9.

Acts 1986, No. 574, §2; Acts 1991, No. 933, §1.

PART XIV. RISK RETENTION GROUP LAW

§2071. Purpose

The purpose of this Part shall be to regulate the formation and operation of risk retention groups in Louisiana, formed pursuant to the provisions of the federal Risk Retention Amendments of 1986, as amended.

Acts 1987, No. 462, §1, eff. Sept. 1, 1987.

§2072. Definitions

As used in this Part, the following terms shall have the meanings ascribed to them in this Section:

(1) "Commissioner" means the commissioner of insurance of Louisiana or the commissioner, director, or superintendent of insurance in any other state.

(2) "Completed operations liability" means liability arising out of the installation, maintenance, or repair of any product at a site which is not owned or controlled by:

(a) Any person who performs that work.

(b) Any person who hires an independent contractor to perform that work; but shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability.

(3) "Domicile," for purposes of determining the state in which a purchasing group is domiciled, means:

(a) For a corporation, the state in which the purchasing group is incorporated.

(b) For an unincorporated entity, the state of its principal place of business.

(4) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able to:

(a) Meet obligations to policyholders with respect to known claims and reasonably anticipated claims.

(b) Pay other obligations in the normal course of business.

(5) "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this state.

(6)(a) "Liability" means legal liability for damages including costs of defense, legal costs and fees, and other claims expenses because of injuries to other persons, damage to their property, or other damage or loss to such other persons resulting from, or arising out of:

(i) Any business, whether profit or nonprofit, trade, product, services including professional services, premises, or operations.

(ii) Any activity of any state or local government, or any agency or political subdivision thereof.

(b) "Liability" does not include personal risk liability and an employer's liability with respect to its employees other than legal liability under the Federal Employers' Liability Act (45 U.S.C. 51 et seq.).

(7) "Personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial, or household responsibilities or activities, rather than from responsibilities or activities referred to in Paragraph (6) of this Section.

(8) "Plan of operation or a feasibility study" means an analysis which presents the expected activities and results of a risk retention group including, at a minimum:

(a) The coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer.

(b) Historical and expected loss experience of the proposed members and national experience of similar exposures.

(c) Pro forma financial statements and projections.

(d) Appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition.

(e) Identification of management, underwriting and claims procedures, managerial oversight methods, investment policies, and reinsurance agreements.

(f) Such other matters as may be prescribed by the department for liability insurance companies authorized by the insurance laws of the state.

(9) "Product liability" means the liability for personal injury and property damages arising from the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product as defined and construed by the laws of this state.

(10) "Purchasing group" means any group domiciled in any state which:

(a) Has as one of its purposes the purchase of liability insurance on a group basis.

(b) Purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in Subparagraph (c) of this Paragraph.

(c) Is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations.

(11) "Risk Retention Amendments of 1986" means Public Law 99-563.

(12) "Risk retention group" means any corporation or other limited liability association formed under the laws of any state, Bermuda, or the Cayman Islands:

(a) Whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members.

(b) Which is organized for the primary purpose of conducting the activity described under Subparagraph (a) of this Paragraph.

(c) Which:

(i) Is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state.

(ii) Before January 1, 1985 was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the insurance commissioner of at least one state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability as such terms were defined in the federal Product Liability Risk Retention Act of 1981 before the date of the enactment of the federal Risk Retention Amendments of 1986.

(d) Which does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person.

(e) Which:

(i) Has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by the risk retention group; or

(ii) Has as its sole owner an organization which has as its members only persons who comprise the membership of the risk retention group, and has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group.

(f) Whose members are engaged in businesses or activities similar or related with respect to the liability of which such members or secondary owners are exposed by virtue of any related, similar, or common business trade, product, services, premises, or operations.

(g) Whose activities do not include the provision of insurance other than:

(i) Liability insurance for assuming and spreading all or any portion of the liability of its group members.

(ii) Reinsurance with respect to the liability of any other risk retention group or any members or secondary owners of such other group which is engaged in businesses or activities so that such group or member or secondary owner meets the requirement described in Subparagraph (g) of this Paragraph from membership in the risk retention group which provides such reinsurance.

(h) The name of which includes the phrase "Risk Retention Group".

(13) "State" means any state of the United States and the District of Columbia.

Acts 1987, No. 462, §1, eff. Sept. 1, 1987; Acts 1995, No. 1203, §1, eff. June 29, 1995.

§2073. Risk retention groups chartered in Louisiana

A. A risk retention group seeking to be chartered in this state shall be chartered and licensed as a liability insurance company authorized by the insurance laws of this state and, except as provided elsewhere in this Part, shall comply with all of the laws, rules, regulations, and requirements applicable to such insurers chartered and licensed in this state and with R.S. 22:2074 to the extent such requirements are not a limitation on laws, rules, regulations, or requirements of this state. Before it may offer insurance in any state, each risk retention group shall also submit for approval to the department of insurance a plan of operation or a feasibility study.

B. A risk retention group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or a feasibility study, on the fifteenth day of the month following the material change. The group shall not offer any additional kinds of liability insurance, in this state or in any other state, until a revision of the plan or study is approved by the department.

Acts 1987, No. 462, §1, eff. Sept. 1, 1987; Acts 1995, No. 1203, §1, eff. June 29, 1995.

§2074. Risk retention groups not chartered in Louisiana

A. Law applicable. Risk retention groups chartered in states other than Louisiana and seeking to do business as a risk retention group in this state shall observe and abide by the laws of this state governing the formation and operation of a risk retention group and the provisions of the federal Risk Retention Amendments of 1986, as amended. However, if a risk retention group fails to qualify under the provisions of the federal Risk Retention Amendments of 1986, the commissioner may apply any state law that may be preempted by the federal Risk Retention Amendments of 1986, as amended.

B. Notice of operations and designation of department as agent. Before offering insurance in this state, a risk retention group shall submit to the department, on a form prescribed by the department:

(1) A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, date of chartering, its principal place of business, its members, and such other information as the commissioner of this state may require to verify that the risk retention group meets the qualifications of R.S. 22:2072(11).

(2) A copy of its plan of operations or a feasibility study and revisions of such plan or study submitted to its state of domicile; except that this Section shall not apply with respect to any line or classification of liability insurance which:

(a) was defined in the Product Liability Risk Retention Act of 1981 before the date of the enactment of this Act; and

(b) was offered before such date of enactment by any risk retention group which has been chartered and operating for not less than three years before such date of enactment.

(3) A statement of registration which designates the commissioner as its agent for the purpose of receiving service of legal documents or process.

(4) Payment of the fee as prescribed by R.S. 22:1078.

C. Financial condition. Any risk retention group doing business in this state shall submit to the commissioner:

(1) A copy of the group's financial statement submitted to its state of domicile, which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist under criteria established by the National Association of Insurance Commissioners.

(2) A copy of each examination of the risk retention group as certified by the commissioner or public official conducting the examination.

(3) A copy of any audit performed with respect to the risk retention group upon request of the commissioner.

(4) Such information as may be required to verify its continuing qualification as a risk retention group under the provisions of R.S. 22:2072(11).

D.(1) Taxation. All premiums paid for coverages within this state to risk-retention groups shall be subject to taxation at the same rate and subject to the same interest, fines, and penalties for nonpayment as that applicable to foreign admitted insurers. To the extent licensed agents or brokers are utilized, they shall report and pay the taxes for the premiums for risks which they have placed with or on behalf of a risk-retention group not chartered in this state. To the extent licensed agents or brokers are not utilized or fail to pay the tax, each risk-retention group shall pay the tax for risks insured with the state. Further, each risk retention group shall report all premiums paid to it for risks insured within the state.

(2) To the extent that licensed insurance agents or brokers are compensated by a risk-retention group, they shall keep a complete and separate record of all policies procured from each risk-retention group. The record shall be open to examination by the department, as provided in R.S. 22:2080. The records shall include for each policy and type of insurance the following:

(a) The limit of liability.

(b) The time period covered.

(c) The effective date.

(d) The name of the risk retention group which issued the policy.

(e) The gross premium charged.

(f) The amount of return premiums, if any.

E. Compliance with unfair claims settlement practices law. Any risk retention group, its agents and representatives, shall comply with the unfair claims settlement practices laws of this state.

F. Deceptive, false, or fraudulent practices. Any risk retention group shall comply with the laws of this state regarding deceptive, false, or fraudulent acts or practices. However, if the commissioner seeks an injunction regarding such conduct, the injunction shall be obtained from a court of competent jurisdiction.

G. Examination regarding financial condition. Any risk retention group shall submit to an examination by the commissioner to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered has not initiated an examination or does not initiate an examination within sixty days after notice from the commissioner of this state. Any such examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the National Association of Insurance Commissioners examiner handbook.

H. Notice to purchasers. Any policy issued by a risk retention group shall contain in ten point type on the front page and the declaration page, the following notice:

"NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group."

I. Prohibited acts regarding solicitation or sale. The following acts by a risk retention group are hereby prohibited:

(1) The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in such group.

(2) The solicitation or sale of insurance by, or operation of, a risk retention group that is in a hazardous financial condition or is financially impaired.

J. Prohibition on ownership by an insurance company. No risk retention group shall be allowed to do business in this state if an insurance company is directly or indirectly a member or owner of such risk retention group, other than in the case of a risk retention group all of whose members are insurance companies.

K. Prohibited coverage. No risk retention group may offer insurance policy coverage prohibited by the Louisiana Insurance Code or declared unlawful by the Louisiana Supreme Court.

L. Delinquency proceedings. A risk retention group not chartered in this state and doing business in this state shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a state insurance commissioner if there has been a finding of financial impairment after an examination under the provisions of Subsection G of this Section.

Acts 1987, No. 462, §1, eff. Sept. 1, 1987; Acts 1995, No. 1203, §1, eff. June 29, 1995; Acts 2004, No. 376, §1.

§2074.1. Additional authority, risk-retention groups

The commissioner may refuse, suspend, or revoke the registration of a risk retention group whenever he shall find that such risk retention group:

(1) Is insolvent.

(2) Is in such condition that its further transaction of business in this state would be hazardous to the policyholders, creditors, or the public.

(3) Fails to pay any fees, taxes, or charges prescribed by this Title within sixty days after the same are due and payable.

(4) Has had its corporate existence dissolved or its certificate of authority revoked or suspended in the state in which it was organized.

(5) Refuses to remove or discharge an officer or director who has been convicted of any felony involving dishonesty or breach of trust, where the convicted person has not been granted a waiver under 18 USC 1033. The provisions of this Paragraph shall not apply to a risk retention group that is not domiciled in this state.

Acts 1995, No. 935, §1; Acts 2004, No. 376, §1.

§2075. Compulsory associations

No risk retention group shall be permitted to join or contribute financially to any insurance insolvency guaranty fund, or similar mechanism, in this state, nor shall any risk retention group, its insureds, or any other claimant receive any benefit from any such fund for claims arising out of the operations of such risk retention group.

Acts 1987, No. 462, §1, eff. Sept. 1, 1987.

§2076. Countersignatures not required

A policy of insurance issued to a risk retention group or any member of that group shall not be required to be countersigned as otherwise provided in the Louisiana Insurance Code.

Acts 1987, No. 462, §1, eff. Sept. 1, 1987.

§2077. Purchasing groups exemption from certain laws relating to the group purchase of insurance

Any purchasing group meeting the criteria established under the laws of this state shall be exempt from any law of this state relating to the creation of groups for the purchase of insurance, prohibition of group purchasing or any law that would discriminate against a purchasing group or its members. In addition, an insurer shall be exempt from any law of this state which prohibits providing or offering to provide to a purchasing group or its members advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages, or other matters. A purchasing group shall be subject to all other applicable laws of this state.

Acts 1987, No. 462, §1, eff. Sept. 1, 1987.

§2078. Notice and registration requirements of purchasing groups

A. A risk purchasing group which intends to do business in this state shall, prior to doing business, pay the registration fee required by R.S. 22:2078.1 and furnish notice to the department on forms prescribed by the department which:

(1) Identify the state in which the group is domiciled.

(2) Specify the lines and classifications of liability insurance which the purchasing group intends to purchase.

(3) Identify the insurance company from which the group intends to purchase its insurance and the domicile of such company.

(4) Identify the principal place of business of the group.

(5) Provide such other information as may be required by the commissioner to verify that the purchasing group is qualified under R.S. 22:2072(10).

B. The purchasing group shall register with and designate the commissioner or other appropriate authority as its agent solely for the purpose of receiving service of legal documents or process, except that such requirements shall not apply in the case of a purchasing group:

(1) Which:

(a) Was domiciled before April 2, 1986.

(b) Is domiciled on and after October 27, 1986 in any state of the United States.

(2) Which:

(a) Before October 27, 1986, purchased insurance from an insurance carrier licensed in any state.

(b) Since October 27, 1986, purchased its insurance from an insurance carrier licensed in any state.

(3) Which was a purchasing group under the requirements of the federal Product Liability Retention Act of 1981 before October 27, 1986.

(4) Which does not purchase insurance that was not authorized for purposes of an exemption under the federal Product Liability Retention Act of 1981, as in effect before October 27, 1986.

C. A purchasing group shall notify the department of any alterations in any of the items required in Subsection A of this Section by the fifteenth day of the following month.

Acts 1987, No. 462, §1, eff. Sept. 1, 1987; Acts 1995, No. 1203, §1, eff. June 29, 1995; Acts 1999, No. 299, §1, eff. June 11, 1999.

§2078.1. Registration and annual renewal; fees

Upon registration with the department, each risk purchasing group shall pay the department a fee of one hundred dollars. Such registration shall expire on the first day of March of each year, unless renewed, and shall be renewed by filing an annual report on a form prescribed by the commissioner and paying a renewal fee of fifty dollars to the department.

Acts 1999, No. 299, §1, eff. June 11, 1999.

§2079. Restrictions on insurance purchased by purchasing groups

A. A purchasing group may not purchase insurance from a risk retention group that is not chartered in a state or from an insurer not admitted in the state in which the purchasing group is located, unless the purchase is effected through a licensed agent or broker acting pursuant to the surplus lines laws and regulations of such state.

B. For purposes of this Section, a purchasing group is located in each and every state in which a member of the purchasing group has a risk or exposure where the liability insured against could arise.

C. A purchasing group which obtains liability insurance from an insurer not admitted in this state or a risk-retention group shall inform each of the members of the group which have a risk located in this state that the risk is not protected by the fund of an insurance guaranty association in this state and that the risk-retention group or insurer may not be subject to all insurance laws and regulations of this state.

D. No purchasing group may purchase insurance providing for a deductible or self-insured retention applicable to the group as a whole. The insurance coverage may provide for a deductible or self-insured retention applicable to individual members.

E. Any purchase of insurance by purchasing groups is subject to the same standards regarding aggregate limits which are applicable to all purchases of group insurance.

Acts 1987, No. 462, §1, eff. Sept. 1, 1987; Acts 1995, No. 1203, §1, eff. June 29, 1995.

§2080. Administrative and procedural authority regarding risk retention groups and purchasing groups

The commissioner may use any of the powers established under the Insurance Code of this state to enforce the laws of this state so long as those powers are not specifically preempted by the federal Product Liability Risk Retention Act of 1981, as amended by the federal Risk Retention Amendments of 1986. This includes, but is not limited to, the commissioner's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders, and impose penalties. With regard to any investigation, administrative proceeding, or litigation, the commissioner may rely on the procedural law and regulations of the state. However, the injunctive authority of the commissioner in regard to risk retention groups is restricted by the requirement that any injunction be issued by a court of competent jurisdiction.

Acts 1987, No. 462, §1, eff. Sept. 1, 1987.

§2081. Penalties

A risk retention group which violates any provision of this Part shall be subject to fines and penalties applicable to licensed insurers generally, including revocation of its license and the right to do business in this state.

Acts 1987, No. 462, §1, eff. Sept. 1, 1987.

§2082. Duty on agents or brokers to obtain license

Any person acting, or offering to act, as an agent or broker for a risk retention group or purchasing group which solicits members, sells insurance coverage, purchases coverage for its members located within the state, or otherwise does business in this state shall obtain a license from the commissioner pursuant to Part XXV of Chapter 1 of this Title.

Acts 1987, No. 462, §1, eff. Sept. 1, 1987; Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996, H.C.R. No. 4, 2002 1st Ex. Sess.

§2083. Binding effect of orders issued in federal district court

An order issued by any district court of the United States enjoining a risk retention group from soliciting or selling insurance, or operating, in any state or in all states or in any territory or possession of the United States upon a finding that such a group is in a hazardous financial condition shall be enforceable in the courts of the state.

Acts 1987, No. 462, §1, eff. Sept. 1, 1987.

§2084. Rules and regulations

The commissioner may establish and, from time to time, amend such rules relating to risk retention groups as may be necessary or desirable to carry out the provisions of this Part.

Acts 1987, No. 462, §1, eff. Sept. 1, 1987.

§2085. Designation

This Part shall be known and may be cited as the "Risk Retention Group Law".

Acts 1987, No. 462, §1, eff. Sept. 1, 1987.

§2086. Policyholder's liability

A. Notwithstanding any other provisions in this Chapter, any contract of insurance issued by an admitted risk retention group may provide for the contingent liability of the policyholder for payment of actual losses and expenses incurred while such contract was in force, provided prior approval is granted by the commissioner of insurance.

B. Each assessable policy issued by an admitted risk retention group shall provide the following notice in ten-point print: "This is an assessable policy. The maximum potential contingent liability shall not exceed one annual premium per annum."

C. The contingent liability of each member of the group for the obligations of the risk retention group shall not be joint but shall be individual and several.

D. "Risk retention group", in this Section, means any corporation or other limited liability association organized pursuant to 15 U.S.C. 3901 and 3902, the Federal Liability Risk Retention Act of 1986, having the following:

(1) The group is chartered or licensed as an insurance company in at least one state and is chartered or licensed as an insurance company or registered as a risk retention group in at least thirty states.

(2) The group maintains admitted assets at all times in an amount which is equal to or exceeds twenty million dollars.

Acts 1990, No. 138, §1.

PART XV. COLLISION DAMAGE WAIVER LAW

§2091. [Blank]

§2091.1. Title of Part

This Part shall be known and may be cited as the "Louisiana Collision Damage Waiver Law".

Acts 1989, No. 773, §2, eff. Jan. 1, 1990.

§2091.2. Scope

This Part shall apply to all persons in the business of leasing rental motor vehicles from locations in this state under an agreement which imposes upon the lessee an obligation to pay for any damages caused to the leased vehicle. The provisions of this Part apply solely to the collision damage waiver portion of the rental agreement which shall not be considered insurance.

Acts 1989, No. 773, §2, eff. Jan. 1, 1990.

§2091.3. Definitions

A. "Collision damage waiver" means any contract or contractual provision, whether separate from or a part of a motor vehicle rental agreement, whereby the lessor agrees for a charge, to waive any and all claims against the lessee for any damages to the rental motor vehicle during the term of the rental agreement.

B. "Lessor" means any person or organization in the business of providing rental motor vehicles to the public.

C. "Lessee" means any person or organization obtaining the use of a rental motor vehicle from a lessor under the terms of a rental agreement.

D. "Rental agreement" means any written agreement setting forth the terms and conditions governing the use of the rental motor vehicle by the lessee.

E. "Rental motor vehicle" means a private passenger type vehicle including passenger cars, passenger vans, and minivans that are primarily intended to transport persons, and which, upon execution of a rental agreement, is made available to a lessee for his use.

Acts 1989, No. 773, §2, eff. Jan. 1, 1990; Acts 1990, No. 589, §1, eff. July 19, 1990.

§2091.4. Notice required; application; fee

A. No lessor shall issue or offer to issue a collision damage waiver in Louisiana until a notice has been filed with the commissioner of insurance as provided in this Part. Notice shall be filed in writing, in a form prescribed by the commissioner, and shall be accompanied by an application fee of one hundred dollars.

B. A lessor of rental motor vehicles with one or more locations within the state will not be required to file more than one notice.

Acts 1989, No. 773, §2, eff. Jan. 1, 1990.

§2091.5. Collision damage waiver; form filing requirements

A. No lessor shall deliver or issue for delivery in this state a rental motor vehicle agreement containing a collision damage waiver unless such agreement is filed with the commissioner at least thirty days prior to its effective date and the commissioner has not disapproved the collision damage waiver portion of such agreement within such thirty days.

B. No collision damage waiver shall be approved unless:

(1) It is written in simple and readable words with common meanings and is understandable.

(2) The terms of the collision damage waiver are prominently displayed, including but not limited to any conditions or exclusions, or both, applicable to the collision damage waiver. The collision damage waiver may exclude the following:

(a) Damages caused intentionally by the lessee or as a result of his willful or wanton misconduct.

(b) Driving while intoxicated or under the influence of any drug, or the combined influence of alcohol and any drug.

(c) Damages caused while engaging in any speed contest.

(d) Damages caused while using the vehicle to push or tow anything, or using the vehicle to carry persons or property for hire, unless authorized by the lessor.

(e) Damages incurred while driving outside the geographical limitations set forth in the contract.

(f) Damages incurred while the vehicle is driven, with the lessee's permission or accession, by anyone other than a person authorized under the contract to drive the vehicle.

(g) The vehicle was leased or an authorized driver approved as a result of fraudulent information provided to the lessor.

(h) Damage caused while committing or as a result of commission of a felony.

(3) All restrictions, conditions, or provisions in or endorsed on a collision damage waiver shall be printed in type as large as brevier or ten point type, or be written in pen and ink or typewritten in or attached to such agreement.

(4) The collision damage waiver includes a statement of the daily charge for the period in question.

(5) The contractual provision containing the collision damage waiver shall display the following notice on its face, in boldface type and in no smaller print than ten point type. The notice shall be explained to the consumer by the lessor and signed and dated by the lessee prior to the consummation of the contract. If the provision is not contained in the contract, then the provision shall be attached to the contract and shall be considered a part thereof.

"NOTICE: IF YOU HAVE COLLISION COVERAGE UNDER YOUR OWN AUTOMOBILE INSURANCE POLICY WRITTEN IN LOUISIANA, YOUR COLLISION COVERAGE AUTOMATICALLY EXTENDS TO RENTAL MOTOR VEHICLES PURSUANT TO R.S. 22:1406(F).

EVEN IF YOU ARE NOT A LOUISIANA INSURED, THE PURCHASE OF COLLISION DAMAGE WAIVER IS NOT MANDATORY AND MAY BE WAIVED. THIS CONTRACT OFFERS, FOR AN ADDITIONAL CHARGE, A COLLISION DAMAGE WAIVER TO COVER YOUR RESPONSIBILITY FOR DAMAGE TO THE VEHICLE. BEFORE DECIDING WHETHER TO PURCHASE THE COLLISION DAMAGE WAIVER, YOU MAY WISH TO DETERMINE WHETHER YOUR OWN AUTOMOBILE INSURANCE AFFORDS YOU COVERAGE FOR DAMAGE TO THE RENTAL VEHICLE AND THE AMOUNT OF THE DEDUCTIBLE UNDER SUCH COVERAGE."

Acts 1989, No. 773, §2, eff. Jan. 1, 1990.

§2091.6. Unfair trade practices

The commissioner may order any lessor which has filed a notice pursuant to this Part, or its officials and representatives, to cease and desist from engaging in the following unfair trade practices:

(1) The making of any false or misleading statements, orally or in writing, in connection with the sale, offer to sell, or advertisement of a collision damage waiver.

(2) The omission of any material statement in connection with the sale, offer to sell, or advertisement of a collision damage waiver, which under the circumstances should have been made in order to prevent the statements that were made from being misleading.

(3) The making of any statement that the purchase of a collision damage waiver is mandatory.

(4) The failure to provide proper disclosure that the purchase of a collision damage waiver may be duplicative of the lessee's automobile insurance contract.

Acts 1989, No. 773, §2, eff. Jan. 1, 1990.

§2091.7. Application of insurance laws

Except as otherwise specifically provided in this Part, none of the other provisions of this Title shall apply to collision damage waivers. None of the provisions of this Part shall apply to the issuance of collision insurance underwritten by an insurer authorized to transact property and casualty business in this state. No lessor to whom this Part applies shall be compelled to join or contribute financially to any plan, pool, association or guaranty or insolvency fund in this state on account of his activities as a lessor.

Acts 1989, No. 773, §2, eff. Jan. 1, 1990.

§2091.8. Injunctions

The commissioner may seek temporary and permanent injunctions restraining violations or attempted violations of this Part in the Nineteenth Judicial District Court.

Acts 1989, No. 773, §2, eff. Jan. 1, 1990.

§2091.9. Penalties

A. Any lessor who is found by the commissioner, after notice and hearing, to have violated or attempted to violate any provision of this Part, may be subject to a penalty under this Section, as determined by the commissioner. Each issuance, procurement, or negotiation of a single collision damage waiver shall be deemed a separate violation.

B. A monetary penalty not to exceed five hundred dollars may be imposed for each violation. No fine or fines shall be imposed against a lessor, pursuant to this Section, which aggregates in excess of ten thousand dollars in any calendar year.

Acts 1989, No. 773, §2, eff. Jan. 1, 1990.

§2091.10. Taxes

The rates charged for the collision damage waiver by a licensee under this Part shall be exempt from insurance taxes and insurance taxation provided that sales taxes in effect in the locale of rental contract issuance are applied, collected, and remitted to the proper tax authority.

Acts 1989, No. 773, §2, eff. Jan. 1, 1990.

PART XVI. LOUISIANA TITLE INSURANCE ACT

§2092. [Blank]

§2092.1. Title; purpose

A. This Part shall be known and cited as the "Louisiana Title Insurance Act".

B. The purpose of this Part is to provide the state of Louisiana with a comprehensive body of law for the effective regulation and supervision of title insurance, title insurers licensed to write title insurance in this state, title insurance agents, and the escrow, accounting, closing, and settlement practices of insurers and agents wherein title insurance is issued or contemplated to be issued.

Acts 1997, No. 1427, §1; Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.2. Definitions

As used only in this Part, the following words are defined as:

(1) "Abstract of title" or "abstract" shall mean a written history, synopsis, or summary of the recorded instruments affecting the title to movable or immovable property.

(2) "Closing" shall mean "settlement" as the term is defined by Paragraph (15) of this Section.

(3) "Department" shall mean the Department of Insurance or its employees, deputies, or representatives or the equivalent department or state entity that provides insurance regulation in another state.

(4) "Depositor" shall mean the person providing the funds or documents for delivery to the depository in connection with a transaction involving immovable property.

(5) "Depository" shall mean the title insurer, title insurance agent, or qualified financial institution receiving a deposit of funds or documents.

(5.1) "Depository check" shall mean a depository check as defined by the Expedited Funds Availability Act, 12 U.S.C. 4001 et seq.

(6) "Escrow" shall mean the act or process of providing closing and settlement services or services pursuant to an escrow agreement by the title insurer or title insurance agent.

(7) "Escrow account" shall mean the demand deposit account maintained by a title insurer or title insurance agent at a qualified financial institution into which the insurer or agent deposits all funds collected from any person who is or will be a party to a transaction involving immovable property in which a title insurance policy is contemplated to be issued.

(8) "Escrow agreement" shall mean the written agreement by which a depositor delivers funds or documents to a title insurer or title agent and which specifies the conditions to be satisfied or the event to be performed before the release or delivery of the funds or documents to another person.

(9) "Escrow instructions" shall mean the written instructions or directions furnished in connection with the closing of a real estate transaction in which title insurance is contemplated to be issued, and shall include but not be limited to a closing or settlement statement, purchase agreement for immovable property, lender's written instructions or directions, escrow agreement, or written directive.

(10) "Funds" shall mean money, or "items" as that term is defined in R.S. 10:4-104(a)(9), and "checks" as that term is defined in R.S. 10:3-104(f).

(11) "Person" shall mean any natural or juridical person, or any partnership, association, cooperative, corporation, firm, trust, limited liability company, or other legal entity.

(12) "Qualified financial institution" shall mean an institution that is:

(a) Organized or licensed under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers.

(b) Regulated, supervised, or examined by federal and state authorities having regulatory authority over banks and trust companies.

(c) Insured by the appropriate federal entity.

(13) "Risks" shall mean the danger or hazards of a loss of title to movable or immovable property by the insured under a title insurance policy.

(14) "Security agreement" shall mean an agreement by which funds or other property are received by the title insurer or the title insurance agent as collateral to secure the obligation of a person under an indemnity agreement to indemnify or protect a title insurer in exchange for agreeing to provide coverage in a title insurance policy.

(15) "Settlement" shall mean the process of executing legally binding documents in a transaction involving either movable or immovable property, including the transfer of title or creation of a lien on the title, or the collection and disbursement of funds in connection therewith.

(16) "Title insurance agent" or "agent" shall mean a person authorized on behalf of the title insurer to issue title insurance reports or policies.

(17) "Title insurance business" or "business of title insurance" shall mean:

(a) Issuing as an insurer or offering to issue as insurer a title insurance policy; or

(b) Transacting or proposing to transact by a title insurer or a title insurance agent any of the following activities when conducted or performed in contemplation of or in conjunction with the issuance of a title insurance report or policy:

(i) Soliciting or negotiating the issuance of a title insurance policy.

(ii) Guaranteeing, warranting, or otherwise insuring the status of title, liens, encumbrances or other matters of record.

(iii) Handling of escrows, settlements, or closings.

(iv) Executing title insurance policies.

(v) Effecting contracts of reinsurance.

(vi) Examining titles; however, any title insurance report or title insurance policy relating to immovable property shall be based upon an examination of title conducted only by attorneys duly licensed and authorized to practice law in Louisiana.

(vii) Collecting, disbursing, or receiving premiums, escrow, settlement, or other funds.

(viii) Recording closing documents.

(c) Doing or proposing to do any business substantially equivalent to any of the foregoing in a manner designed to evade the provisions of this Part.

(18) "Title insurance policy" or "policy" shall mean a contract, including any affirmative assurances, enhancements to coverage, or endorsements, insuring or indemnifying owners of, or other persons lawfully interested in, movable or immovable property against loss or damage arising from any or all of the following conditions existing on, before, or subsequent to the policy date and not specifically excepted or excluded:

(a) Defects in or liens or encumbrances on the insured title.

(b) Unmarketability of the insured title.

(c) Invalidity or unenforceability of liens or encumbrances on the insured title of the movable, where a title search is required for the purpose of registration, or immovable property.

(d) Title being vested otherwise than as stated in the policy.

(e) Lack of a legal right of access to the land which is part of the insured title in a policy relating to immovable property.

(f) Lack of priority of the lien of any insured mortgage over any statutory lien for services, labor, or materials as specifically described in the policy.

(g) Invalidity or unenforceability of any assignment of an insured mortgage subject to certain conditions.

(h) The priority of any lien or encumbrance over the lien of the insured mortgage.

(19) "Title insurance report" or "report" shall mean a preliminary report, commitment, or binder issued prior to the issuance of a title insurance policy containing the requirements, terms, conditions, exceptions, and any other matters incorporated by reference under which the title insurer is willing to issue its title insurance policy.

(20) "Title insurer" or "insurer" shall mean a company authorized under the laws of this state to transact the business of title insurance.

(21) "Underwrite" shall mean the acceptance or rejection of risk on behalf of the title insurer.

Acts 1997, No. 1427, §1; Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.3. Title insurers and agents; qualifications

Only those persons authorized as a title insurer or agent pursuant to this Title shall be qualified to issue a title insurance policy or report or otherwise transact the business of title insurance. Notwithstanding any other law to the contrary, all title insurance policies and reports covering any insurable interest in title to immovable property located in this state shall be signed by an agent licensed in this state under this Part or by an employee of a title insurer issuing the title insurance policies and reports when such employee is an agent licensed in this state under this Part.

Acts 1997, No. 1427, §1; Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.4. Authorized activities; title insurers

Subject to the exceptions and restrictions contained in this Part, a title insurer shall have the power to:

(1) Do only title insurance business.

(2) Reinsure title insurance policies.

(3) Perform, or cause to be performed, ancillary activities, unless prohibited by the department, including examining title to and furnishing related information about movable or immovable property and procuring and furnishing information about relevant personal property, whether or not in contemplation of, or in conjunction with, the issuance of a title insurance report or policy; however, any such activities that are defined by R.S. 37:212 as the practice of law shall only be performed by an attorney duly licensed and authorized to practice law in Louisiana.

Acts 1997, No. 1427, §1; Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.5. Title insurers; limitation of authority, powers

A.(1) No insurer that transacts any class, type, or kind of insurance other than title insurance shall be eligible for the issuance or renewal of a license to transact the business of title insurance in this state.

(2) No title insurance shall be transacted, underwritten, or issued by any insurer transacting or licensed to transact any other class, type, or kind of business.

B. No title insurer shall engage in the business of guaranteeing payment of the principal or the interest on bonds or mortgages.

C.(1) Notwithstanding Subsection A of this Section, a title insurer may issue closing or settlement protection to a person who is a party to a transaction in which a title insurance policy is contemplated to be issued. The closing or settlement protection shall conform to the terms of coverage and form of instrument as may be required by the department and may indemnify a person solely against loss of settlement funds because of the following acts of a settlement agent, title insurer's named employee, or title insurance agent:

(a) Theft or misappropriation of settlement funds.

(b) Failure to comply with instructions when agreed to by the settlement agent, employee, or title insurance agent.

(2) The premium charged by a title insurer for this coverage shall be submitted to and approved by the Louisiana Insurance Rating Commission.

(3) A title insurer shall not provide any other coverage which purports to indemnify against improper acts or omissions of a person with regard to escrow or settlement services.

Acts 1997, No. 1427, §1; Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.6. Title insurance agents; licensing and reporting requirements

Every title insurance agent licensed in the state shall provide, in a timely fashion, each title insurer with which it places business all information the title insurer may request in compliance with the licensing and reporting requirements of the department.

Acts 1997, No. 1427, §1; Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.6.1. Title insurance agents; errors and omissions requirements

A. Every title insurance agent licensed in this state shall maintain an errors and omissions policy, which includes coverage for their acts or omissions as a title insurance agent, for the benefit of the title insurer or the depositor in amounts, under terms and conditions, and from insurers approved by the department, after considering the reasonableness of the cost and availability thereof.

B. The title insurance agent shall furnish the title insurer with proof that the agent complies with this Section.

Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.7. Title insurance agents; examination

The department or title insurer may during normal business hours examine, audit, and inspect any and all books, records, files, and escrow and operating accounts related to the title insurance business maintained by a title insurance agent, its successor in interest, transferee, or receiver as provided under this Part.

Acts 1997, No. 1427, §1; Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.8. Underwriting contracts required, title insurer, agent

A. No person acting in the capacity of a title insurance agent shall place business with a title insurer, and no title insurer shall accept business from a title insurance agent, unless there exists a written contract between the parties. The written contract shall establish the responsibilities of each party, and where both parties share responsibility for a particular function, specify the division of such responsibilities. The written contract shall also contain the following provisions as a minimum:

(1) The basis of the rates to be charged.

(2) The types of risks which may be undertaken.

(3) Maximum authority or limits of liability.

(4) Territorial limitations.

(5) Guidelines for title searches and examinations.

(6) Underwriting guidelines.

(7) All terms of compensation for the title insurance agent.

(8) Policies and funds remittance.

(9) Termination provisions.

B. The contract shall not be assigned in whole or in part by the title insurance agent without the express written consent of the title insurer.

Acts 1997, No. 1427, §1; Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.8.1. Title insurance agent; policies and funds remittance

A. Unless a later date is specifically authorized by the title insurer for a particular transaction, the title insurance agent shall account for and remit all funds and policies due under the contract to the title insurer by the earlier of:

(1) Sixty days after the effective date of the policy.

(2) The time specified by the underwriting contract.

B. Notwithstanding the provisions of Subsection A of this Section, when a report has been issued, the title insurance agent shall account for and remit all funds and policies due under the contract to the title insurer within sixty days after satisfaction of all requirements and conditions of the report.

C. The premium for any policy of insurance shall be due and payable at the settlement of the transaction.

D. No title insurer or title insurance agent shall issue a title insurance report wherein the issuance of a policy of insurance is not contemplated.

Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.8.2. Title insurance agent; termination

A. The title insurer may terminate the contract upon written notice to the title insurance agent under any of the following circumstances:

(1) Fraud, insolvency, appointment of a receiver or conservator, bankruptcy, cancellation of the license or permit to do business of the agent, or the commencement of legal proceedings by the state of the domicile of the agent, which if successful, would lead to the cancellation of the permit or license to do business of the agent.

(2) Material breach of any provision of the contract between the title insurer and the title insurance agent.

(3) In accordance with any other termination provision of the contract.

B. Upon the effective date as set forth in the notice of termination from a title insurer, unless otherwise agreed to in writing by the title insurer, the agent shall immediately discontinue all title insurance business on behalf of that title insurer.

C. Nothing in this Subsection shall relieve the title insurance agent or title insurer of any other contractual obligation.

Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.8.3. Title insurance agent; claims

It shall be the duty of the title agent to immediately report and forward to the title insurer all claims reported to the agent by policyholders or other persons.

Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.8.4. Title insurance agent; restrictions

The title insurance agent shall not:

(1) Bind reinsurance on behalf of the title insurer.

(2) Permit any of its directors, officers, controlling shareholders, or employees to serve on the title insurer's board of directors if the title insurance agent wrote one percent or more of the direct premiums of the title insurer written in the previous calendar year as shown on the title insurer's most recent annual statement filed with the department. This Subsection shall not apply to relationships governed by R.S. 22:1001 through 1015.

(3) Jointly employ an individual who is employed with the title insurer unless the title insurer and the title insurance agent are affiliated or otherwise under common control as defined by R.S. 22:1002(3).

Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.8.5. Title insurance agent; inventory maintenance

The title insurance agent shall maintain an inventory of all numbered policy forms or policy numbers assigned to the agent by the title insurer.

Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.9. Title insurer; audit

A. The title insurer shall, at least once every three years, conduct an on-site audit of the escrow and settlement practices, escrow accounts, security arrangements, files, underwriting and claims practices, and policy inventory of the agent. If the title agent fails to maintain separate escrow or trust accounts for each title insurer it represents, the title insurer shall verify that the funds related to closings in which the title insurer's policies are issued are reasonably ascertainable from the books of account and records of the title agent.

B. The department may promulgate regulations setting forth the standards of audit and the form of audit required. The department may also require the title insurer to provide a copy of its audit reports to the department.

Acts 1997, No. 1427, §1; Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.9.1. Title insurer; agency appointment and termination

Within five days of executing or terminating a contract with a title insurance agent, the title insurer shall provide written notification of the appointment or termination and the reason for termination to the department. All notices of appointment and termination of a title insurance agent shall be made on a form promulgated by the department.

Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.9.2. Title insurer; restrictions

A title insurer shall not:

(1) Appoint any director, officer, controlling shareholder, or employee of a title insurance agent to serve on the title insurer's board of directors if the title insurance agent wrote one percent or more of the direct premiums of the title insurer written during the previous calendar year as shown on the title insurer's most recent annual statement on file with the department. This Subsection shall not apply to relationships governed by R.S. 22:1001 through 1015.

(2) Jointly employ an individual who is employed with the title insurance agent unless the title insurer and the title insurance agent are affiliated or otherwise under common control as defined by R.S. 22:1002(3).

(3) Engage in the practice of law as defined by R.S. 37:212.

Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.9.3. Title insurer; inventory maintenance

The title insurer shall maintain an inventory of all numbered policy forms or policy numbers allocated to each title insurance agent.

Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.9.4. Title insurer; agency licensing and errors and omissions insurance requirements

The title insurer shall have on file evidence that each appointed title insurance agent is licensed by the state and maintains the errors and omissions insurance required by this Part.

Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.10. Policyholder rights and disclosure

A. A title insurer or a title insurance agent issuing a title insurance policy to a lender in conjunction with a mortgage loan involving immovable property made simultaneously with the purchase of all or part of the immovable estate securing the loan, when no owner's title insurance policy has been requested, shall give written notice, on a form prescribed or approved by the department, to the purchaser-mortgagor at the closing.

B. The notice shall explain that a title insurance policy for the lender involving immovable property is issued for the protection of the mortgage lender, and that the policy does not provide title insurance protection to the purchaser-mortgagor as the owner of the immovable property being purchased.

C. The notice shall explain what a title policy relating to immovable property insures and what possible exposures exist for the purchaser-mortgagor of immovable property that could be insured through the purchase of an owner's title policy involving immovable property. The notice shall also explain that the purchaser-mortgagor may obtain an owner's title insurance policy at a specified premium.

D. A copy of the notice, signed by the purchaser-mortgagor, shall be retained in the closing file for at least three years after the effective date of the lender's title insurance policy.

Acts 1997, No. 1427, §1; Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.11. Maintenance, conditions; escrow, closing, or settlement services, deposit accounts by title insurer or its agent

A. A title insurer or a title insurance agent may operate in a fiduciary capacity as a closing, escrow, or settlement agent, provided that:

(1) All funds deposited with the title insurer or the title insurance agent in connection with any closing, escrow agreement, or security agreement shall be deposited or submitted for collection to a qualified financial institution no later than the close of the next business day following receipt or, in the case where a borrower has a right of rescission, no later than the close of the next business day following the termination of the right of rescission, in accordance with the following requirements:

(a) All funds collected for the business of title insurance shall be deposited and held in an escrow account as defined herein, in the name of the title insurer or title insurance agent and clearly titled as an escrow, settlement, closing, or trust account.

(b) The funds shall be property of the person or persons entitled to them under the provisions of the escrow instructions, and shall be identified for each depositor in the manner that permits the funds to be identified on an individual basis.

(c) The funds shall be used only in accordance with the terms of the escrow instructions.

(2) Funds held in an escrow account shall be disbursed only pursuant to escrow instructions specifying how and to whom the funds may be disbursed.

(3) Funds held in a security agreement for the purpose of clearing, writing over, or insuring over an exception to title shall be disbursed only pursuant to a written agreement specifying:

(a) The necessary actions to satisfy the obligation under the arrangement.

(b) The duties of the title insurer or the title insurance agent with respect to disbursement of the funds held, including a requirement to maintain evidence of the disposition of the title exception before any balance may be paid over to the depositor or his or her designee.

(4) Funds held in connection with a real estate closing where no escrow instructions or security agreement is applicable shall be disbursed in accordance with a signed closing or disbursement statement.

B. All disbursements shall be drawn out of an escrow account only if:

(1) The funds directly relating to the transaction are in amounts at least equal to the disbursements;

(2) The funds are in the possession of the title insurer or title insurance agent; and

(3) The funds are in one or more of the following forms:

(a) Cash.

(b) Wire transfers unconditionally received by the title insurer or the title insurance agent or the depository of the insurer or agent.

(c) A depository check, including a certified check, cashier's check, or teller's check as defined by the Expedited Funds Availability Act, 12 U.S.C. 4001 et seq.

(d) A personal check or other item which has been presented for payment and for which funds have been unconditionally collected by the title insurer or the title insurance agent.

(e) Credit transfers through the Automated Clearing House which have been deemed available by the depository institution receiving the credit. The credit shall conform to the operating rules established by the National Automated Clearing House Association.

(f) Checks unconditionally issued by mortgage lenders which are subject to periodic audit by the Department of Housing and Urban Development or the secretary of Veterans Affairs, and which are drawn on financial institutions insured by the Federal Deposit Insurance Corporation.

(g) A check or checks, drawn on the trust account or sales escrow account of the real estate broker licensed under R.S. 37:1430 et seq., in an amount up to the amount of the then current guarantee provided by the Real Estate Recovery Fund as established in R.S. 37:1463.

(h) A personal or commercial check or checks in an aggregate amount not exceeding two thousand five hundred dollars per closing if the settlement agent making the deposit has reasonable and prudent grounds to believe that the deposit will be irrevocably credited to the settlement agent's trust or escrow account.

(i) Checks unconditionally issued by credit unions chartered by applicable state or federal statute.

(j) Checks unconditionally issued by municipalities or political subdivisions of the state of Louisiana.

(k) Checks drawn on the escrow accounts of title insurers or title insurance agents when the title insurance agent issuing the check shall have certified by affidavit the following:

(i) That funds drawn at the time of the real estate closing and settlement are from an escrow account as defined by R.S. 22:2092.2(6).

(ii) That the funds disbursed are from those funds received by the title insurance agent at the time of the real estate closing and settlement and were in one of the forms enumerated in Paragraph B(3) of this Subsection.

C. REPEALED BY ACTS 1999, No. 192, §2, eff. June 9, 1999.

D. Nothing in this Part shall be deemed to prohibit the recording of documents prior to the time funds are available for disbursement with respect to a transaction, provided all parties consent to the recordation in writing.

E. Nothing in this Section is intended to amend, alter, or supersede other provisions of this Part or of the laws of this state or the United States regarding the duties and obligations of an escrow agent.

Acts 1997, No. 1427, §1; Acts 1999, No. 192, §§1, 2, eff. June 9, 1999.

§2092.12. Record retention; requirements

The title insurer and the title insurance agent shall maintain sufficient records of their affairs, including evidence of the examination of title and determination of insurability and records of its escrow operations and escrow accounts. The department may prescribe the specific record entries and documents to be kept and the length of time for which the records shall be maintained.

Acts 1997, No. 1427, §1.

§2092.13. Louisiana Insurance Code; applicability to title insurers, title insurance agents

All title insurers and title insurance agents shall be subject to all other applicable provisions of this Title unless specifically exempted by this Part.

Acts 1997, No. 1427, §1; Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.14. Rules and regulations; promulgated by department

The department shall issue rules, regulations, and directives, in accordance with the Administrative Procedure Act to implement the provisions of this Part.

Acts 1997, No. 1427, §1; Acts 1999, No. 192, §1, eff. June 9, 1999.

§2092.15. Penalties; liabilities

A. If the department determines that the title insurer or the title insurance agent or any other person has violated this Part, or any rule, regulation, or order promulgated thereunder, the department, pursuant to R.S. 22:1351 et seq., may order:

(1) If a corporation, a penalty not exceeding fifty thousand dollars for each violation, and if a natural person, a penalty not exceeding ten thousand dollars for each violation.

(2) Revocation or suspension of the license of the title insurance agent or the certificate of authority of the title insurer.

B. If an order of rehabilitation or liquidation of the insurer or of conservation of assets of the insurer has been entered pursuant to R.S. 22:732 through 774, and the receiver appointed under that order determines that the title insurance agent or any other person has not complied with this Part, or any related rule, regulation or order, and the insurer suffered any resulting loss or damage thereunder, the receiver shall maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer and its policyholders and creditors.

C. Nothing contained in this Section shall affect the right of the department to impose any other penalties provided for in Chapter 1 of this Title.

D. Nothing contained in this Part is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, and creditors of the title insurer or the title insurance agent.

Acts 1997, No. 1427, §1.

§2092.16. Limits of scope

Nothing contained in this Part shall be deemed to amend, supersede, or repeal any provision of R.S. 37:212 and 213.

Acts 1997, No. 1427, §1.

PART XVII. LIMITED LICENSING FOR MOTOR VEHICLE RENTAL COMPANIES

§2101. Purpose

This Part is to govern the qualifications and procedures for the limited licensing of motor vehicle rental or leasing companies to sell or offer insurance in conjunction with the rental of a vehicle as provided in this Part. This Part shall govern the transactions covered in this Part of selling travel or automobile-related products or coverage in connection with and incidental to the rental of vehicles.

Acts 1999, No. 1278, §1, eff. July 12, 1999.

§2102. Definitions

As used in this Part, the following words are defined as follows:

(1) "Commissioner" shall mean the commissioner of insurance.

(2) "Department" shall mean the Department of Insurance.

(3) "Limited licensee" means a person or entity authorized to sell certain coverages relating to the rental of vehicles pursuant to the provisions of this Part.

(4) "Rental agreement" means any written agreement setting forth the terms and conditions governing the use of a vehicle provided by the rental company for rental or lease.

(5) "Rental company" means any person or entity in the business of providing primarily private passenger vehicles to the public under a rental agreement for a period not to exceed ninety days.

(6) "Rental period" means the term of the rental agreement.

(7) "Renter" means any person obtaining the use of a vehicle from a rental company under the terms of a rental agreement for a period not to exceed ninety days.

(8) "Vehicle" or "rental vehicle" means a motor vehicle of the private passenger type including passenger vans, minivans, and sport utility vehicles, and of the cargo type including but not limited to cargo vans, pickup trucks and trucks with a gross vehicle weight of less than twenty-six thousand pounds and which do not require the operator to possess a commercial driver's license.

Acts 1999, No. 1278, §1, eff. July 12, 1999.

§2103. Limited licensing; fees

A. The commissioner may issue to a rental company, whether such rental company is a foreign or domestic company, that has complied with the requirements of this Part, a limited license authorizing the limited licensee and its employees to offer or sell insurance in connection with the rental of vehicles.

B. As a prerequisite for issuance of a limited license under this Part, there shall be filed with the commissioner a written application for a limited license along with a five hundred dollar-application fee, signed by an officer of the applicant, in such form or forms, and supplements thereto, and containing such information, as the commissioner may prescribe by rule or regulation. Every limited licensee shall, every two years, notify the commissioner of his intention to continue its license on forms provided by the commissioner and shall submit a renewal fee of two hundred fifty dollars. However, for a licensee who maintains twenty-five or less vehicles, the initial application fee shall be one hundred dollars and the renewal fee shall be fifty dollars.

Acts 1999, No. 1278, §1, eff. July 12, 1999.

§2104. License requirements

Upon the filing of an application and the payment of the license fee, the department shall make an investigation of each applicant and may issue a license if it finds that the applicant complies with all of the following items:

(1) Has provided a detailed plan of operation.

(2) Is competent and trustworthy and intends to act in good faith in the capacity involved for which the license is applied.

(3) Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied.

(4) Meets all other requirements of this Part.

Acts 1999, No. 1278, §1, eff. July 12, 1999.

§2105. Rental vehicle insurance

A. The rental company licensed pursuant to this Part may offer or sell insurance only in connection with and incidental to the rental of vehicles, whether at the rental office or by preselection of coverage in a master, corporate, individual, or group rental agreement, in any of the following general categories:

(1) Personal accident insurance covering the risks of travel including but not limited to accident and health insurance that provides coverage, as applicable, to renters and other rental vehicle occupants for accidental death or dismemberment and reimbursement for medical expenses resulting from an accident that occurs during the rental period.

(2) Liability insurance that provides coverage, as applicable, to renters and other authorized drivers of rental vehicles for liability arising from the operation of the rental vehicle.

(3) Personal effects insurance that provides coverage, as applicable, to renters and other vehicle occupants for the loss of or damage to personal effects that occurs during the rental period.

(4) Roadside assistance and emergency sickness protection programs.

(5) Any other travel or automobile-related coverage that a rental company offers in connection with and incidental to the rental of vehicles.

B. No insurance may be offered by a limited licensee pursuant to this Part unless all of the following items are satisfied:

(1) The rental period of the rental agreement does not exceed ninety consecutive days.

(2) At every rental location where rental agreements are executed, brochures or other written materials are readily available to the prospective renter that:

(a) Summarize clearly and correctly, the material terms of coverage offered to renters, including the identity of the insurer.

(b) Disclose that these policies offered by the rental company may provide a duplication of coverage already provided by a renter's personal automobile insurance policy, homeowner's insurance policy, personal liability insurance policy, or other source of coverage.

(c) State that the purchase by the renter of the kinds of coverage specified in this Part is not required in order to rent a vehicle.

(d) Describe the process for filing a claim in the event the renter elects to purchase coverage and in the event of a claim.

(3) Evidence of coverage in the rental agreement is disclosed to every renter who elects to purchase such coverage.

Acts 1999, No. 1278, §1, eff. July 12, 1999.

§2106. Authorized employees

A. Any limited license issued under this Part shall also authorize any employee of the limited licensee to act individually on behalf, and under the supervision, of the limited licensee with respect to the kinds of coverage specified in this Part.

B. Each rental company licensed pursuant to this Part shall conduct a training program in which employees being trained shall receive basic instruction about the kinds of coverage specified in this Part and offered for purchase by prospective renters of rental vehicles.

Acts 1999, No. 1278, §1, eff. July 12, 1999.

§2107. Insurance charges

Notwithstanding any other provision of this Part or any rule adopted by the commissioner, a limited licensee pursuant to this Part shall not be required to treat monies collected from renters purchasing such insurance when renting vehicles as funds received in a fiduciary capacity, provided that the charges for coverage shall be itemized and be ancillary to a rental transaction. The sale of insurance not in conjunction with a rental transaction is prohibited by the provisions of this Part.

Acts 1999, No. 1278, §1, eff. July 12, 1999.

§2108. Representations

No limited licensee under this Part shall advertise, represent, or otherwise hold itself or any of its employees or agents out as licensed insurers, insurance agents, or insurance brokers.

Acts 1999, No. 1278, §1, eff. July 12, 1999.

§2109. List of authorized persons

The limited licensee shall keep a list of all persons who are authorized or who are selling insurance as provided in this Part. The list shall be produced to the commissioner within two weeks of written demand from the commissioner.

Acts 1999, No. 1278, §1, eff. July 12, 1999.

§2110. Penalties for violations

In the event that any provision of this Part or other applicable provision of this Title is violated by a limited licensee, the commissioner may revoke, suspend, refuse to renew, or levy a fine not to exceed one thousand dollars for each violation, up to one hundred thousand dollars in the aggregate for all violations in a calendar year per limited licensee, or impose such other penalty as the commissioner may deem necessary or convenient to carry out the purposes of this Part.

Acts 1999, No. 1278, §1, eff. July 12, 1999.

§2111. Applicability of this Part

All limited licensees under this Part shall be subject to all other applicable provisions of this Title unless specifically exempted by this Part.

Acts 1999, No. 1278, §1, eff. July 12, 1999.

§2112. Rules and regulations; promulgated by department

The commissioner shall issue such rules, regulations, and directives, in accordance with the Administrative Procedure Act to implement the provisions of this Part.

Acts 1999, No. 1278, §1, eff. July 12, 1999.

CHAPTER 3. SELF-INSURERS

§3001. Scope of provisions

A. This Chapter shall be applicable to and shall regulate self-insurers and self-insurance plans, as defined in this Chapter, which are subject to jurisdiction of the commissioner of insurance under Chapter 1 of this Title. This Chapter shall not be applicable to any worker's compensation plan, except as otherwise provided in this Chapter.

B. Regulation under this Chapter shall not be deemed to and shall not make any self-insurer or insurance plan an insurer or insurance policy solely because of such regulation hereunder. Any entity regulated under this Chapter shall not be considered or treated as an insurer or insurance policy solely because of such regulation.

Acts 1984, No. 857, §1; Acts 1990, No. 902, §1; Acts 1992, No. 612, §1.

§3002. Definitions

For purposes of this Chapter, unless the context clearly indicates otherwise, the following terms shall have the meanings ascribed to them:

(1)(a) "Self-insurance plan" means any contract, plan, trust, arrangement, or other agreement which is established or maintained to offer or provide health care services, indemnification, or payment for health care services, or health and accident benefits to employees of two or more employers, but which is not fully insured. Any such contract, plan, trust, arrangement, or agreement shall be deemed "fully insured" only if said services, indemnification, payment, or benefits are guaranteed under a contract or policy of health insurance issued by an insurer authorized to transact business in this state.

(b) The term "self-insurance plan" shall not include single employer plans, plans exempt from the state insurance laws under the provisions of the Employee Retirement Income Security Act of 1974 (29 U.S.C. §1001 et seq.), except as provided in R.S. 22:3013, the Office of Group Benefits, plans of political subdivisions, health maintenance organizations regulated under the Health Maintenance Organization Act, R.S. 22:2001 et seq., plans regulated under R.S. 33:1342, 1343, 1346, or 1349, and plans otherwise regulated as insured plans under this Title. A plan of a fraternal benefit society or a labor organization shall not be considered a self-insurance plan for the purposes of this Chapter to the extent that such plan provides health and accident benefits to its members and any of their dependents that are supplemental to those of an employer-provided plan.

(2) "Self-insurer" means any entity that makes, provides, or issues a self-insurance plan as defined in this Section.

(3) "Single employer plans" are:

(a) Those providing benefits to the employees of only one employer.

(b) Those providing benefits to the employees of two or more employers if at least a twenty-five percent interest in each such employer is held by the same legal entity directly or through subsidiaries.

Acts 1984, No. 857, §1; Acts 1990, No. 902, §1; Acts 1992, No. 775, §1; Acts 2001, No. 1178, §2, eff. June 29, 2001.

§3003. Certificate of authority

A. It is unlawful for any self-insurer to transact business or to issue or provide health care benefits under or pursuant to a self-insurance plan in this state without a certificate of authority issued by the commissioner of insurance. Any self-insurer which transacts business in this state without the certificate of authority required by this Chapter shall be considered an unauthorized insurer within the meaning of Part XXVII of Chapter 1 of this Title and all remedies and penalties prescribed therein shall apply to such self-insurer.

B. Each application for a certificate of authority shall be made on forms prescribed by the commissioner, shall be verified by the self-insurer or its authorized representative, and shall set forth or be accompanied by the following:

(1) A copy of the plan's bylaws and all management, administration, or trust agreements which the plan has made or proposes to make for the conduct of its business and affairs. Any proposed change or amendment to the foregoing shall also be filed with the commissioner within sixty days of its implementation.

(2) A list of names, permanent addresses, and official positions, if any, of the persons responsible for the formation of the self-insurer and for the organization, establishment, administration, and maintenance of the self-insurance plan.

(3) A copy of the application for coverage, contract, certificate, or policy of insurance or schedules of benefits to be issued or provided to persons covered under the self-insurance plan.

(4) A current financial statement verified by the applicant or its authorized representative showing the applicant's assets, liabilities, and sources of financial means and support.

(5) A copy of all advertising and marketing materials, including the marketing plan.

C. Within ninety days of receipt of a completed application, the commissioner of insurance shall issue a certificate of authority to do business in the state to an applicant if the commissioner determines that the following conditions are met:

(1) The persons responsible for the administration of the self-insurance plan are competent, trustworthy, and of good reputation.

(2) The applicant is financially sound and responsible.

(3) The applicant has deposited cash or securities and has otherwise complied with all of the requirements of this Chapter.

Acts 1984, No. 857, §1; Acts 1990, No. 902, §1.

§3004. Insolvency deposit

A. Prior to the issuance of any certificate of authority under this Chapter, each applicant shall deposit with the commissioner safekeeping receipts or trust receipts from insured banking or other financial institutions chartered to do business in the state of Louisiana, evidencing that the applicant has deposited with said institutions one million dollars, or such other amount as may be authorized by Subsection E of this Section, in cash to guarantee its financial responsibility. No single deposit shall exceed the insured deposit limit of any such banking or financial institution.

B. Each receipt or other evidence of deposit or security shall contain a restriction which shall read as follows:

"ACKNOWLEDGEMENT OF RESTRICTION

The cash or other deposit evidenced by this receipt shall be held by the issuer or its successors or assigns, to demonstrate to the Louisiana Department of Insurance that the owner-payee of the receipt is financially responsible and capable of performing its obligations as a self-insurer. This certificate shall be renewed and renegotiated between the issuer and the owner-payee without the necessity of the receipt's release or surrender and funds evidenced hereby shall remain on deposit at or with the issuing institution, its successors or assigns, until notice of release or a demand of payment signed by the duly authorized elected incumbent commissioner of insurance of the state of Louisiana, or his duly authorized deputy, has been presented to issuer. Any issuer making payment to the commissioner upon his written demand and upon a showing of good cause shall not be liable in any manner to the owner-payee or any other person for having made such disbursement of funds. Interest earned on the funds evidenced hereby shall be paid to the owner-payee on a regular periodic basis as agreed to by the issuer and the owner-payee."

C.(1) In lieu of the one million dollar aggregate deposit or deposits required by Subsection A of this Section, each self-insurer applying for a certificate of authority may deposit with the commissioner an irrevocable letter or letters of credit issued in his favor in the amount of one million dollars in the aggregate, which shall be issued and maintained subject to the terms and conditions hereinafter set forth. The letter or letters of credit shall be issued by an insured banking or other insured financial institution chartered to do business in the state of Louisiana.

(2) Each letter of credit shall be issued for a term of three years from the date thereof. Once issued, the letter of credit shall not be cancelled regardless of the financial status of the applicant or the financial institution during the term thereof. Every letter of credit shall contain a provision providing for the automatic extension, renewal, or reissuance after the initial three-year term, from year to year, unless notice to the contrary by the issuing financial institution is given to the commissioner by registered mail not less than ninety days prior to the expiration date. Upon receipt of notice that the letter or letters of credit will not be renewed, the commissioner shall have the following options:

(a) He may convert the letter or letters of credit to a cash deposit by calling for funding or payment in full thereon.

(b) He may accept a substitute letter or letters of credit if they meet the requirements of this Section.

(c) He may convert the letter or letters of credit to a cash deposit and suspend the certificate of authority issued to the self-insurer.

D.(1) No letter or letters of credit issued as provided for in this Section shall be revoked, cancelled, terminated, substituted, or withdrawn by any issuing bank or financial institution without the written approval of, and ninety days prior written notice to, the commissioner, such notice to be given by registered mail, return receipt requested. Upon receipt of any such notice, the commissioner may exercise the powers and options granted in Subsection C of this Section with respect to the letter or letters of credit. The commissioner shall give written notice of the option to be exercised to the issuing financial institution and the self-insurer at least ten days prior to termination of the letter or letters of credit. The issuer of the letter or letters of credit shall fully fund the letter or letters of credit within twenty-four hours after receipt of notice to do so by the commissioner.

(2) Upon failure of any bank or financial institution to fund any letter or letters of credit, the commissioner shall apply to the Nineteenth Judicial District Court in and for the parish of East Baton Rouge for a rule to show cause why the letter or letters of credit should not be funded.

E. After the first year of the transaction of business in this state by a self-insurer, the deposit required under this Section shall be:

(1) For each insurer which, by July 1, 1990, has not filed its plan with the commissioner as required by law, an amount which is the greater of either one million dollars or twenty-five percent of the annual gross premium receipts of the self-insurer for the immediately preceding calendar year.

(2) For each insurer which, by July 1, 1990, has filed its plan with the commissioner as required by law, an amount which is the greater of either:

(a)(i) One-third of one million dollars, by July 1, 1991;

(ii) Two-thirds of one million dollars, by July 1, 1992;

(iii) One million dollars, by July 1, 1993 and thereafter; or

(b) Twenty-five percent of the annual gross premium receipts of the self-insurer for the immediately preceding calendar year.

(3) For each trade or professional association with membership limited predominantly to Louisiana which has sponsored a health insurance plan for the benefit of its members for at least six consecutive years prior to the enactment* date of this Act, the deposit required under this Section shall not apply until July 1, 1995.

Acts 1984, No. 857, §1; Acts 1990, No. 902, §1.

*AS APPEARS IN ENROLLED BILL.

§3005. Administrators; license

An administrator of a self-insurance plan shall be licensed as a life and health insurance agent and shall be subject to all laws and regulations governing life and health insurance agents as set forth in Part XXV of Chapter 1 of this Title.

Acts 1984, No. 857, §1; Acts 1990, No. 902, §1; Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996, H.C.R. No.4, 2002 1st Ex. Sess.

§3006. Agents; appointment

A. Any self-insurer who has been issued a certificate of authority under this Chapter may contract with and appoint as its representatives in this state, as its agent or agents, any person or persons licensed as a life and health agent under Chapter 1 of this Title. No solicitation of insurance shall be made by any agent prior to notification of such self-insurer that its appointment has been recorded by the commissioner of insurance. If the commissioner has not notified the self-insurer of his disapproval of a particular agent within thirty days after receipt of the self-insurer's appointment of such agent, the agent thereafter may commence solicitation of insurance.

B. On or before the first day of March of each year, each self-insurer shall submit to the commissioner of insurance by certified mail an alphabetical list of the licensed agents which it wishes to appoint, together with a fee of ten dollars for each such appointment. Any appointment shall remain in full force and effect until the thirtieth day of April following the date of recordation by the commissioner of insurance, unless the license of the appointed agent is revoked by the commissioner or until cancelled by the self-insurer upon written notice to the agent and the commissioner.

C. Any self-insurer who violates the provisions of this Section shall be fined the sum of ten dollars for each agent's appointment received after the first day of March of each year.

Acts 1984, No. 857, §1; Acts 1990, No. 902, §1.

§3007. Agents; acting for unauthorized self-insurer prohibited

A. No natural or juridical person shall, within this state, solicit, procure, receive, or forward applications for coverage under any self-insurance plan or issue or deliver policies, certificates, schedules of benefits, or other evidence of such coverage or in any manner secure, assist, or aid in the placing of any such coverage for any person other than himself, directly or indirectly, with any self-insurer not authorized to do business in this state under this Chapter.

B. Any such person shall be liable personally for the full amount of any loss sustained under such coverage provided by or through him or it, directly or indirectly, with any self-insurer not authorized to do business in this state, including any taxes which may become due under the laws of this state by reason of such coverage.

C. The commissioner may revoke, suspend, or refuse to renew an agent's, broker's, or solicitor's license, or may levy a fine not to exceed two thousand five hundred dollars against an agent, broker, or solicitor who, after notice and hearing, has been found by the commissioner to have violated the provisions of this Section.

Acts 1984, No. 857, §1; Acts 1990, No. 902, §1.

§3008. Self-insured trusts

The following requirements shall be met in addition to all other provisions of this Chapter where any self-insurance plan is effected, maintained, and operated under a trust agreement:

(1) A board of trustees elected by participating employers shall serve as fund managers on behalf of participants. Trustees shall be plan participants. No participating employer may be represented by more than one trustee. A minimum of three and a maximum of seven trustees may be elected. Trustees may not receive compensation but may be reimbursed for actual expenses incurred in connection with duties as trustee.

(2) Trustees shall be bonded in an amount not less than one hundred fifty thousand dollars from a licensed surety company.

(3) Investment of plan funds is subject to the same restrictions which are applicable to insurers under this Title. All investments shall be managed by a bank or other financial institution chartered in the state of Louisiana.

Acts 1984, No. 857, §1; Acts 1990, No. 902, §1.

§3009. Excess stop-loss coverage

Each self-insurance plan shall include aggregate excess stop-loss coverage and specific excess stop-loss coverage provided by an insurer licensed by the state of Louisiana. Aggregate excess stop-loss coverage shall include provisions to cover incurred, unpaid claims liability in the event of plan termination. The excess or stop-loss insurer shall bear the risk of coverage for any employer participating in the self-insurance plan that becomes insolvent with outstanding contributions due. The plan shall have a participating employer's fund in an amount at least equal to the point at which the excess or stop-loss insurer shall assume one hundred percent of additional liability. A plan shall submit its proposed excess or stop-loss insurance contract to the commissioner at least thirty days prior to the proposed self-insurance plan's effective date and at least thirty days subsequent to any renewal date. The commissioner shall review the contract to determine whether it meets the standards established by this Section and shall respond within thirty days of its submission to him. Any excess or stop-loss insurance plan must provide coverage with rates not subject to adjustment by the insurer during the first twelve months.

Acts 1984, No. 857, §1; Acts 1990, No. 902, §1.

§3010. Disclosures

A. No contract, certificate, policy, schedule of benefits, or other evidence or agreement of insurance shall be delivered or issued for delivery in this state under any self-insurance plan unless there is prominently printed on the front thereof in ten-point type a notice to the insured that the plan pursuant to which the coverage is issued or provided is uninsured.

B. Each application for coverage under a self-insurance plan and any and all advertisements or marketing pieces or material disseminated in relation to any self-insured plan shall contain a statement prominently printed thereon or therein in ten point type that the self-insurance plan for which coverage is being solicited is uninsured.

C. Any entity, including but not limited to a production agency or third party or other administrator, that advertises, sells, transacts, or administers coverage for health care services in this state, shall inform any purchaser or prospective purchaser of coverage under a self-insurance plan or person covered under a self-insurance plan of the lack of insurance for the coverage issued or provided or to be issued or provided. Any administrator that advertises or administers coverage for health care services in this state that is provided by a self-insurer shall inform its appointed production agencies and agents of the elements of coverage, including the amount of any reinsurance or "stop-loss" insurance in effect.

Acts 1990, No. 902, §1.

§3011. Annual examination; rate review

A. Each self-insurer shall cause to be conducted an annual examination by a licensed independent certified public accountant of its financial statements reporting the financial condition and results of operations of the self-insurer.

B. This Section shall apply to all self-insurers; however, a self-insurer having direct premiums in this state of less than two hundred fifty thousand dollars in any year and having less than five hundred policyholders in this state at the end of any year shall be exempt from this Section for such year unless the commissioner makes a specific finding that compliance is necessary for the commissioner to carry out statutory responsibilities.

C. The audit report required in this Section shall be filed with the commissioner on or before the thirtieth day of the sixth month following the year end of the self-insurer. Up to two thirty-day extensions may be granted by the commissioner upon showing by the self-insurer and its independent certified public accountant of the reasons for requesting such extension and upon determination by the commissioner of good cause for an extension. The request for extension shall be submitted in writing not less than ten days prior to the due date in sufficient detail to permit the commissioner to make an informed decision with respect to the requested extension.

D. The annual audited financial statement shall report the financial condition of the self-insurer as of the end of the most recent fiscal or calendar year and the results of its operations, changes in financial position, and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the Department of Insurance of the state of domicile of the self-insurer.

E. The annual audited financial report shall include the following:

(1) Report of independent certified public accountant.

(2) Balance sheet reporting admitted assets, liabilities, capital, and surplus.

(3) Statement of gain or loss from operations.

(4) State of cash flows.

(5) Statement of changes in capital and surplus.

(6) Notes to financial statements. These notes shall be those required by generally accepted accounting principles and shall include:

(a) A reconciliation of difference, if any, between the audited statutory financial statements and the annual statement filed pursuant to this Chapter with a written description of the nature of these differences.

(b) A narrative explanation of all significant intercompany transactions and balances.

(7) The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the commissioner, and:

(a) The financial statement shall be comparative.

(b) Amounts may be rounded to the nearest thousand dollars.

(c) Insignificant amounts may be combined.

F. Financial statements furnished pursuant to this Section shall be examined by an independent certified public accountant. The examination of the self-insurer's financial statements shall be conducted in accordance with generally accepted auditing standards.

G. Every self-insurer required to file an audited financial report pursuant to this Chapter shall require the accountant to make available for review by the commissioner, the workpapers prepared in the conduct of his examination. The insurer shall require that the accountant retain the audit workpapers for a period of not less than five years after the period reported thereon.

H. In the conduct of the aforementioned review by the commissioner, photocopies of pertinent audit workpapers may be made and retained by the department. Such working papers or copies thereof obtained by the commissioner shall be confidential and shall not constitute a public record. The workpapers of a certified public accountant subject to maintenance and examination pursuant to this Section shall nonetheless remain the property of the certified public accountant.

I. With the commissioner's approval, an insurer may comply with this Chapter by filing the requisite reports which have been prepared in accordance with generally accepted accounting principles, provided that the notes to the financial statements include a reconciliation of differences between net income and capital and surplus on the annual statement filed pursuant to this and comparable totals on the audited financial statements, with a written description of the nature of these differences.

J. Upon the request of the commissioner of insurance, each group self-insurance fund established pursuant to R.S. 23:1191 shall cause a rate review to be conducted by a national independent actuarial firm, provided that the commissioner shall not make more than two requests in any calendar year for a rate review under the provisions of this Subsection. Such firm shall report its findings to the commissioner of insurance.

Acts 1990, No. 902, §1; Acts 1992, No. 612, §1.

§3012. Examination by commissioner

A. The commissioner of insurance shall make an annual examination of each self-insurer for the initial three-year period during which the self-insurer transacts business in this state. Thereinafter, the commissioner shall make an examination of each self-insurer at least once every five years, unless the commissioner, in his discretion, determines that the financial condition or operations of the self-insurer warrant more frequent examinations.

B. All expenses incurred by the commissioner in conducting the examination shall be paid by the self-insurer examined. A self-insurer may contest the reasonableness of the amount of the expenses billed to it by applying to a court of competent jurisdiction for a rule to test the reasonableness of the billing. The rule shall be tried by preference and, if appealed, shall be given preference in the appellate court as may be provided for suits against the state.

C. If a self-insurer does not contest the reasonableness of the billing and fails to pay the expenses of the examination within thirty days after the receipt of the billing or within fifteen days after the date that a final judgment was rendered when a rule had been issued pursuant to Subsection B of this Section, the commissioner may file a lien against any of the assets of the self-insurer located within the state until the amount of the lien is paid in full.

D. The commissioner shall employ such personnel as is necessary to conduct the examination and to compile the report thereon.

E. In conducting an examination of a self-insurer, the commissioner shall have access to all records of the self-insurer and those pertaining to the self-insurance plan of the self-insurer. All such records and the officers, employees, and representatives of the self-insurer shall be made available to the commissioner.

F. If the self-insurer fails to make the records or personnel available as provided in Subsection E, the commissioner may petition any court of competent jurisdiction to subpoena witnesses or documentary evidence. The commissioner shall have the power to administer oaths and examine under oath any person relative to the insurance affairs of the self-insured being examined. Any person who testifies falsely or makes a false affidavit during the course of such an examination shall be guilty of perjury.

G. The commissioner shall make a certified report of his findings and a copy shall be furnished to the self-insurer at least thirty days prior to the filing of the report in the office of the commissioner for public inspection. During this thirty-day period, the self-insurer may request in writing that a hearing be held to consider objections to the report. The report shall not be made public until after the hearing is held and any modifications that the commissioner deems necessary are made.

Acts 1990, No. 902, §1; Acts 1997, No. 1449, §1.

§3013. Annual reports

A. Each self-insurer shall file on or before the first day of March of each year an annual auditor's statement and an annual report signed by the person in charge of the self-insurance plan which shall certify the amount of gross annual premiums or contributions of the participating employers and their employees for the preceding year, the financial condition of the plan, an itemization of plan expenditures, and any other information as may be required by the commissioner.

B. Any plan established or maintained in the state to offer or provide health care services, indemnification, or payment for health care services, or health and accident benefits to employees under the provisions of the Employee Retirement Income Security Act of 1974 (29 U.S.C. §1001 et seq.) shall file, through the administrator or his designee, within two hundred ten days after the close of such year a certified copy of the annual report required pursuant to 29 U.S.C. §1023 with the commissioner. The filing required herein shall in no way purport to regulate or affect the plan or its benefits.

Acts 1990, No. 902, §1; Acts 1992, No. 775, §1.

§3014. Dissolution

A. A self-insurer that desires to dissolve a self-insurance plan shall apply to the commissioner for authority to dissolve. Applications to dissolve shall be on forms prescribed by the commissioner and shall be approved or disapproved by the commissioner within sixty days of receipt. Dissolution of a self-insurer or a self-insurance plan without authorization is prohibited and shall not absolve a plan, a self-insurer, or its participants from fulfilling the plan's continuing obligations.

B. An application to dissolve shall be granted if either of the following conditions is met:

(1) The plan has no outstanding liabilities including incurred but not reported liabilities.

(2) The plan is covered by an irrevocable commitment from a licensed insurer which provides for payment of all outstanding liabilities and for providing all related services, including payment of claims, preparation of reports, and administration of transactions associated with the period during which the plan provided coverage.

C. Upon dissolution of any self-insured trust, after payment of all outstanding liabilities and indebtedness, the assets of the plan shall be distributed to all employers participating in the plan during the last five years immediately preceding dissolution. The distributive share of each employer shall be in the proportion that all contributions made by the employer during the five-year period bear to the total contributions made by all participating employers during such five-year period.

Acts 1990, No. 902, §1.

§3015. Insolvency of plan

When the commissioner, after examination or review of the audit statement required under R.S. 22:3013, finds that a self-insurance plan is nearing an insolvent condition or is insolvent, he may issue such orders as he deems necessary to rehabilitate the plan, or he may petition a court of competent jurisdiction for an injunction and rehabilitation as provided for in Part XVI of Chapter 1 of this Title.

Acts 1990, No. 902, §1.

§3016. Transaction of business; required filings

A. Each self-insurer doing business in this state on September 3, 1984, shall by January 1, 1985, file with the commissioner a complete copy of its plan including eligibility requirements, employee contributions, benefits provided, limitations on and exclusions from coverage, and provisions relating to the termination of individual coverages.

B. Except as otherwise specifically provided in this Chapter, each self-insurer doing business in this state or issuing or providing in this state a self-insurance plan on September 7, 1990, shall take all actions necessary for full compliance with the provisions of this Chapter by July 1, 1991.

C. No self-insurer shall transact business in this state or shall issue or provide any coverage for health and accident benefits under any self-insurance plan until it has complied with all applicable requirements of this Chapter and of any other applicable provisions of this Title, including R.S. 22:11.

D. Each self-insurer shall pay fees in advance in the amount specified in R.S. 22:1078 for its filings, certificates, copies, and other services specified therein which are applicable to self-insurers.

E. The commissioner may take any action available to him under this Title to ensure compliance with and to enforce the provisions of this Chapter.

Acts 1990, No. 902, §1; Acts 1993, No. 653, §1.

§3017. Duties of commissioner; rules and regulations

A. The commissioner shall, no later than September 1, 1990, transmit a notice by first class mail to each licensed agent who is authorized to market self-insurance regulated by this Chapter. The notice shall summarize the provisions of this Chapter and shall particularly specify the restrictions and prohibitions which apply to such agents, including but not limited to the provisions of R.S. 22:3007 relative to an agent's personal liability and sanctions.

B. The commissioner shall promulgate such rules and regulations in accordance with the Administrative Procedure Act as are necessary to effectuate the provisions and purposes of this Chapter.

Acts 1990, No. 902, §1.

§3018. Covered claim; prohibition of cancellation

No self-insurer may unilaterally cancel a self-insurance plan or reduce the benefits provided by such plan after receipt or notice of any covered claim. The self-insurer may cancel the plan, as otherwise provided by law, after the claimant has been discharged from treatment for that condition and no further claims for that condition are expected, provided there has been no other receipt or notice of claim by that claimant under that plan.

Acts 1993, No. 944, §1.

§3018.1. Inherited metabolic diseases; coverage for food products

A. Every self-insurer and self-insurance plan, as defined in this Chapter, which are subject to the jurisdiction of the commissioner under Chapter 1 of this Title shall provide coverage, subject to applicable deductibles, coinsurance, and copayments, for low protein food products for treatment of inherited metabolic diseases, if the low protein food products are medically necessary and, if applicable, are obtained from a source approved by the self-insurer or self-insurance plan, provided coverage will not be denied if the self-insurer or self-insurance plan does not approve a source.

B. As used in this Section, the following words shall have the following meanings:

(1) "Inherited metabolic disease" shall mean a disease caused by an inherited abnormality of body chemistry. Such diseases shall be limited to:

(a) Glutaric Acidemia.
(b) Isovaleric Acidemia (IVA).
(c) Maple Syrup Urine Disease (MSUD).
(d) Methylmalonic Acidemia (MMA).
(e) Phenylketonuria (PKU)
(f) Propionic Acidemia.
(g) Tyrosinemia.

(h) Urea Cycle Defects.

(2) "Low protein food products" shall mean a food product that is especially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. Low protein food products shall not include a natural food that is naturally low in protein.

C. Coverage provided pursuant to this Section shall not exceed eligible benefits of two hundred dollars per month.

D. The provisions of this Section shall apply to any new policy, contract, program, or plan issued by an entity subject to the provisions of this Section on or after January 1, 2004. Any such policy, contract, program, or plan in effect prior to January 1, 2004, shall convert to the provisions of this Section on or before the renewal date thereof but in no event later than January 1, 2005.

Acts 2003, No. 829, §1.

CHAPTER 4. LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER HEALTH MAINTENANCE ORGANIZATION

§3021. Establishment of the Louisiana State University Health Sciences Center Health Maintenance Organization

A. The Board of Supervisors of Louisiana State University and Agricultural and Mechanical College may create a health maintenance organization, to be called the Louisiana State University Health Sciences Center Health Maintenance Organization, which shall include all hospitals, clinics, and such medical service provider organizations as shall be established by or under the direct control of the Louisiana State University Health Sciences Center.

B. Subject to the approval of the commissioner of insurance, the chancellor of the Louisiana State University Health Sciences Center may promulgate rules and regulations, in accordance with the procedures provided in R.S. 17:1519.2(D), to create the Louisiana State University Health Sciences Center Health Maintenance Organization and to institute some collection of payment from the enrollees of the Louisiana State University Health Sciences Center Health Maintenance Organization. Such rules and regulations shall provide for a board of the organization which represents both patients and health care professionals. Such rules and regulations shall specify the organizational features of the organization which shall, except for minimum financial requirements and the requirements for incorporation, comply with the provisions of Part XII of Chapter 2 of this Title. The minimum financial requirements and the requirements for incorporation provided in said Part XII for health maintenance organizations, are hereby waived for the organization created as provided in this Section.

C. The rules and regulations for which provision is made in Subsection B of this Section shall further provide for the organization membership by enrollees in the Louisiana State University Health Sciences Center Health Maintenance Organization.

D. All health care providers on staff at any hospital as described in this Section shall be entitled to participate as providers in this health maintenance organization.

E. The rates charged for services by the Louisiana State University Health Sciences Center Health Maintenance Organization shall be based on actuarially derived costs of providing care to the same population as certified by the Department of Health and Hospitals.

F. The Louisiana State University Health Sciences Center Health Maintenance Organization shall be limited to persons eligible for Medicaid or eligible for enrollment in a managed care plan pursuant to the state Medicaid plan and pursuant to Title XIX (Medicaid) of the Social Security Act or a successor to the Medicaid program.

G. The Louisiana State University Health Sciences Center Health Maintenance Organization shall enter into a contract with any willing provider licensed by the Louisiana State Board of Medical Examiners or the Louisiana State Board of Dental Examiners to provide primary care services delivered in an outpatient setting including medical and surgical services. Such providers shall satisfy the standards that are established as part of the approved managed care plan relating to quality, utilization, and accessibility of services.

H. All Medicaid managed care plans implemented as part of this Section shall be limited to programs implemented by the Department of Health and Hospitals in accordance with state law.

I. All Medicaid managed care plans implemented as part of this Section shall be subject to approval by the commissioner of insurance and legislative approval as set forth in R.S. 17:1519.2(D).

J. The rules and regulations shall provide that persons eligible for enrollment shall have the freedom to choose among all health maintenance organizations providing services to such persons, shall insure that such persons are informed of their right to choose, and shall provide a process through which persons who fail to make a choice are assigned to one of the health maintenance organizations authorized and eligible to provide services to such persons.

Acts 1997, No. 3, §2, eff. July 1, 1997; Acts 1999, No. 802, §2, eff. July 2, 1999.

§3022. Traditional providers access retained

The establishment of the Louisiana State University Health Sciences Center Health Maintenance Organization shall not interrupt the patient-doctor relationship that has been established by non-Louisiana State University Health Sciences Center admitting providers. Persons eligible for Medicaid, the uninsured, and medically indigent residents of the state and others in need of medical care shall retain access to traditional providers of medical care who are licensed by the Louisiana State Board of Medical Examiners and the Louisiana State Board of Dentistry.

Acts 1997, No. 3, §2, eff. July 1, 1997; Acts 1999, No. 802, §2, eff. July 2, 1999.

CHAPTER 5. THIRD-PARTY ADMINISTRATION

§3031. Definitions

The following terms shall have the following meanings:

(1) "Administrator" or "third-party administrator" or "TPA" means any individual, partnership, corporation, or other person, except an employee of a fund or plan that serves as an administrator, who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this state, or residents of another state from offices in this state, in connection with life or health insurance coverage or annuities, or who is engaged by any group self-insurance funds or plan of self-insurance providing accident and health protection or worker's compensation coverage to its members or employees to implement the policies of the trustees of the fund and to provide for day-to-day management of the fund, except any of the following:

(a) An employer on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of such employer.

(b) A union on behalf of its members.

(c) An insurer which is authorized to transact insurance in this state, but only with respect to a fully insured policy lawfully issued and delivered in and pursuant to the laws of this state or another state or, an insurer which is authorized to transact insurance in this state and which has capital and surplus of at least fifty million dollars, as evidenced by the insurer's annual statement filed in accordance with R.S. 22:1451, as of December thirty-first of the preceding year.

(d) An agent or broker licensed to sell life or health insurance in this state, whose activities are limited exclusively to the sale of insurance.

(e) A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors.

(f) A trust and its trustees, agents, and employees acting pursuant to such trust established in conformity with 29 U.S.C. Section 186.

(g) A trust exempt from taxation under Section 501(a) of the Internal Revenue Code, its trustees and employees acting pursuant to such trust, or a custodian and the custodian's agents or employees acting pursuant to a custodian account which meets the requirements of Section 401(f) of the Internal Revenue Code.

(h) A credit union or a financial institution which is subject to supervision or examination by federal or state banking authorities, or a mortgage lender, to the extent they collect and remit premiums to licensed insurance agents or authorized insurers in connection with loan payments.

(i) A credit card issuing company which advances for and collects premiums or charges from its credit card holders who have authorized collection if the company does not adjust or settle claims.

(j) A person who adjusts or settles claims in the normal course of that person's practice or employment as an attorney at law and who does not collect charges or premiums in connection with life or health insurance coverage or annuities.

(k) An adjuster licensed by this state whose activities are limited to the adjustment of claims.

(l) A person who acts solely as an administrator of one or more bona fide employee benefit plans established by an employer or an employee organization, or both, for which the insurance laws of this state are preempted pursuant to the Employee Retirement Income Security Act of 1974. Such person shall comply with the requirements of R.S. 22:3041(G).

(m) A person licensed as a managing general agent in this state, whose activities are limited exclusively to the scope of activities conveyed under such license.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Commissioner" means the commissioner of insurance through the Department of Insurance.

(4) "Control" as defined in R.S. 22:1002.

(5) "Insurance" or "insurance coverage" means any coverage offered or provided by an insurer. For the purposes of this Chapter, the term shall also mean any coverage for worker's compensation benefits or health and accident protection offered by a group self-insurance fund or any plan of self-insurance for which the insurance laws of this state are preempted pursuant to the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(6) "Insurer" means any person undertaking to provide life or health and accident insurance coverage or worker's compensation insurance in this state. For the purposes of this Chapter, insurer includes a licensed insurance company, a prepaid hospital or medical care plan, a health maintenance organization, a multiple employer welfare arrangement, or any other person or entity providing such coverages for its members or employees a plan of insurance subject to state insurance regulation. "Insurer" shall not include a bona fide employee benefit plan established by an employer or an employee organization, or both, for which the insurance laws of this state are preempted pursuant to the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(7) "Underwrites" or "underwriting" means but is not limited to the acceptance of employer or individual applications for coverage of individuals in accordance with the written rules of the insurer, the overall planning and coordinating of an insurance program, and the ability to procure bonds and excess insurance.

Acts 1993, No. 144, §1; Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996.

§3032. Necessity of written agreement

A. No administrator shall act as such without a written agreement between the administrator and the insurer and such written agreement shall be retained as part of the official records of both the insurer and the administrator for the duration of the agreement and for five years thereafter. The agreement shall contain all provisions required by this statute, except insofar as those requirements do not apply to the functions performed by the administrator.

B. The written agreement shall include a statement of the duties which the administrator is expected to perform on behalf of the insurer and the lines, classes, or types of insurance which the administrator is to be authorized to administer. The agreement shall make provision with respect to underwriting or other standards pertaining to the business underwritten by such insurer.

C. The insurer or administrator may, with written notice, terminate the written agreement for cause as provided in the agreement. The insurer may suspend the underwriting authority of the administrator during the pendency of any dispute regarding the cause for termination of the written agreement. The insurer must fulfill any lawful obligations with respect to policies affected by the written agreement, regardless of any dispute between the insurer and the administrator.

Acts 1993, No. 144, §1.

§3033. Payment to administrator

If an insurer utilizes the services of an administrator, the payment to the administrator of any premiums or charges for insurance by or on behalf of the insured party shall be deemed to have been received by the insurer, and the payment of return premiums or claim payments forwarded by the insurer to the administrator shall not be deemed to have been paid to the insured party or claimant until such payments are received by the insured party or claimant. Nothing in this Section limits any right of the insurer against the administrator resulting from the failure of the administrator to make payments to the insurer, insured parties, or claimants.

Acts 1993, No. 144, §1.

§3034. Maintenance of information

A. Every administrator shall maintain and make available to the insurer complete books and records of all transactions performed on behalf of the insurer. The books and records shall be maintained in accordance with prudent standards of insurance recordkeeping and must be maintained for a period of not less than five years from the date of their creation.

B. The commissioner shall have access to books and records maintained by an administrator for the purposes of examination, audit, and inspection. Any trade secrets contained in such books and records, including the identity and addresses of policyholders and certificate holders, shall be kept confidential, except that the commissioner may use such information in any proceeding instituted against the administrator.

C. If the agreement between the insurer and the administrator provides that the insurer owns the records generated by the administrator pertaining to the insurer, the administrator shall retain the right of continuing access to those books and records to permit the administrator to fulfill all of its contractual obligations to insured parties, claimants, and the insurer.

D. In the event the insurer and the administrator cancel their agreement, notwithstanding the provisions herein, the administrator may transfer all records to the insurer or a succeeding administrator selected by the insurer and licensed in the state, rather than retain them for five years. In the event of a cancellation under this Subsection, the succeeding administrator or the insurer shall acknowledge and agree, in writing, that the administrator or insurer shall be responsible for retaining the records of the prior administrator as required herein.

Acts 1993, No. 144, §1.

§3035. Insurer; underwriting; advertisement

An administrator may use only such advertising pertaining to the business underwritten by an insurer that has been approved in writing by the insurer in advance of its use.

Acts 1993, No. 144, §1.

§3036. Duties of the insurer

A. If an insurer utilizes the services of an administrator, the insurer shall be responsible for determining the benefits, premium rates, underwriting criteria, and claims payment procedures applicable to such coverage and for securing reinsurance, if any. The rules pertaining to these matters must be provided, in writing, by the insurer to the administrator. The responsibilities of the administrator as to any of these matters shall be set forth in the written agreement between the administrator and the insurer.

B. It shall be the sole responsibility of the insurer to provide for competent administration of its programs.

C. In cases where an administrator administers benefits for more than one hundred certificate holders on behalf of an insurer, the insurer may, at least semiannually, conduct a review of the operations of the administrator. At least one such review may be an on-site audit of the operations of the administrator.

Acts 1993, No. 144, §1.

§3037. Premium collection and payment of claims

A. All insurance charges or premiums or plan contributions collected by an administrator on behalf of or for an insurer or insurers, and the return of premiums received from that insurer or insurers, shall be held by the administrator in a fiduciary capacity. Such funds shall be immediately remitted to the person or persons entitled to them or shall be deposited promptly in a fiduciary account established and maintained by the administrator in a federally or state insured financial institution. Funds held in a fiduciary account or a claims paying account shall not be used for payment of any business operating expenses of the administrator. The written agreement between the administrator and the insurer shall provide for the administrator to periodically render an accounting to the insurer detailing all transactions performed by the administrator pertaining to the business underwritten by the insurer.

B. If charges or premiums deposited in a fiduciary account have been collected on behalf of or for one or more insurers, the administrator shall keep records clearly recording the deposits in and withdrawals from the account on behalf of each insurer. The administrator shall keep copies of all the records and, upon request of an insurer, shall furnish the insurer with copies of the records pertaining to such deposits and withdrawals.

C. The administrator shall not pay any claim by withdrawals from a fiduciary account in which premiums or charges are deposited. Any withdrawal from such account shall be made as provided in the written agreement between the administrator and the insurer. The written agreement shall address but not be limited to the following:

(1) Remittance to an insurer entitled to remittance.

(2) Deposit in an account maintained in the name of the insurer.

(3) Transfer to and deposit in a claims-paying account, with claims to be paid in full compliance with Subsection D of this Section.

(4) Payment to a group policyholder for remittance to the insurer entitled to such remittance.

(5) Payment to the administrator of its commissions, fees, or charges.

(6) Remittance of return premium to the person or persons entitled to such return premium.

D. All claims paid by the administrator from funds collected on behalf of or for an insurer shall only be paid on drafts or checks of and as authorized by the insurer.

Acts 1993, No. 144, §1.

§3038. Administrator; compensation

A. An administrator shall not enter into any agreement or understanding with an insurer in which the effect is to make the amount of the administrator's commissions, fees, or charges contingent upon savings effected in the adjustment, settlement, and payment of losses covered by the insurer's obligations. This provision shall not prohibit an administrator from receiving performance-based compensation for providing hospital or other auditing services.

B. This Section shall not prevent the compensation of an administrator from being based on premiums or charges collected or the number of claims paid or processed.

Acts 1993, No. 144, §1.

§3039. Notice to covered individuals; disclosure of charges and fees

A. When the services of an administrator are utilized, the administrator shall provide a written notice approved by the insurer to covered individuals advising them of the identity of, and relationship among, the administrator, the policyholder, and the insurer.

B. When an administrator collects funds, the reason for collection of each item must be identified to the insured party and each item must be shown separately from any premium. The insured or participant of the plan shall not be charged for the same services by both the insurer and the administrator.

C. The administrator shall disclose to the insurer all charges, fees, and commissions received from all services in connection with the provision of administrative services for the insurer, including any fees or commissions paid by insurers providing reinsurance.

Acts 1993, No. 144, §1.

§3040. Coverage; notice to individuals

Any policies, certificates, booklets, termination notices, or other written communications delivered by the insurer to the administrator for delivery to insured parties or covered individuals shall be delivered by the administrator promptly, after receipt of instructions from the insurer to deliver them.

Acts 1993, No. 144, §1.

§3041. Licensure required

A. No person shall act as, or offer to act as, or hold himself out to be an administrator in this state without a valid license as an administrator issued by the commissioner. The commissioner may impose a fine of five thousand dollars per violation against any person who acts as an administrator without a valid license, and each day shall be considered a separate violation.

B. Applicants under this Section shall pay a licensing fee in an amount set forth in R.S. 22:1078 and shall make an application to the commissioner upon a form to be furnished by the commissioner. The application shall include or be accompanied by the following information and documents:

(1) All basic organizational documents of the administrator, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement, and other applicable documents and all amendments to such documents.

(2) The bylaws, rules, regulations, or similar documents regulating the internal affairs of the administrator.

(3) The names, addresses, official positions, and professional qualifications of the individuals who are responsible for the conduct of affairs of the administrator, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, the principal officers in the case of a corporation or the partners or members in the case of a partnership or association, shareholders holding directly or indirectly ten percent or more of the voting securities of the administrator, and any other person who exercises control or influence over the affairs of the administrator.

(4) An affidavit signed by the president or other authorized officer stating that the administrator has available for inspection by the commissioner, its latest financial statement.

(5) The applicant shall submit summary information concerning its business organization and employees sufficient to fulfill the requirements of this Chapter.

(6) If the applicant will be managing the solicitation of new or renewal business, proof that it employs or has contracted with an agent licensed by this state for solicitation and taking of applications. Any applicant who intends to directly solicit insurance contracts or to otherwise act as an insurance agent must provide proof that he has a license as an insurance agent in this state.

(7) Such other pertinent information as may be required by the commissioner.

C. The applicant shall make available for inspection by the commissioner copies of all contracts with insurers or other persons utilizing the services of the administrator.

D. The commissioner may refuse to issue a license if the commissioner determines that the administrator, or any individual responsible for the conduct of affairs of the administrator as defined herein, is not competent, trustworthy, financially responsible or of good personal and business reputation, or has had an insurance or an administrator license denied or revoked for cause by any state.

E. A license issued under this Section shall remain valid, unless surrendered, suspended, or revoked by the commissioner, for so long as the administrator continues in business in this state and remains in compliance with this Chapter.

F. An administrator is not required to hold a license as an administrator in this state if all of the following conditions are met:

(1) The administrator has its principal place of business in another state.

(2) The administrator is not soliciting business as an administrator in this state.

(3) In the case of any group policy or plan of insurance serviced by the administrator, fewer than one hundred certificate holders reside in this state.

G. A person shall not be required to maintain a license as an administrator under this Chapter if the person acts solely as the administrator of one or more bona fide employee benefit plans established and maintained by an employer or an employee organization, or both, for which the insurance laws of the state are preempted pursuant to the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.). The person exempted herein shall register with the commissioner annually to verify their status.

H. An administrator shall immediately notify the commissioner of any material change in its ownership, control, or other fact or circumstance affecting its qualification for a license in this state.

I.(1) An administrator shall maintain and keep in full force and effect a surety bond in an amount of one hundred thousand dollars issued by an authorized surety company doing business in this state, or deposit with the commissioner a safekeeping or trust receipt from a bank doing business in the state or from a savings and loan association chartered to do business in this state indicating that the administrator has deposited one hundred thousand dollars in money, or bonds of the United States, the state of Louisiana, or any political subdivision thereof of the par value of one hundred thousand dollars. The surety bond or the money or the securities shall be held in trust for the benefit and protection of and as security for all policyholders of the insurer and participants of the plan with whom the administrator contracts. The provisions of this Paragraph shall not apply to administrators required to post a suretybond in accordance with provisions of R.S. 23:1192(A)(7), in providing services for a group self-insurance fund for workers' compensation insurance.

(2) No bond shall be required by the commissioner for any administrator whose business is restricted solely to benefit plans which are either fully insured by an authorized insurer or which are bona fide employee benefit plans established by an employer or any employee organization, or both, for which the insurance laws of this state are preempted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

Acts 1993, No. 144, §1; Acts 2004, No. 372, §1.

§3042. Waiver of application for certification

Upon request from an administrator, the commissioner may waive the application requirements herein if the administrator has a valid license as an administrator issued in a state which has standards for administrators that are at least as stringent as those contained in the model statute for third-party administrators of the National Association of Insurance Commissioners.

Acts 1993, No. 144, §1.

§3043. Annual report; filing fee

A. Each administrator shall file an annual report for the preceding calendar year with the commissioner on or before March first of each year, or within such extension of time therefor as the commissioner may grant for good cause. The report shall be in the form and contain all information as the commissioner requires and shall be verified by at least two officers of the administrator.

B. The annual report shall include the complete names and addresses of all insurers with which the administrator had an agreement during the preceding fiscal year.

C. At the time of filing its annual report, the administrator shall pay a filing fee in the amount set forth in R.S. 22:1078.

Acts 1993, No. 144, §1.

§3044. Grounds for suspension or revocation of license

A. The license of an administrator shall be suspended or revoked, or in lieu of said revocation, a fine may be imposed for each separate violation, not to exceed five thousand dollars per violation, or twenty-five thousand dollars in the aggregate, if the commissioner finds that the administrator:

(1) Is using such methods or practices in the conduct of its business so as to render its further transaction of business in this state hazardous or injurious to insured persons or the public.

(2) Has failed to pay any judgment rendered against it in this state within sixty days after the judgment has become final.

B. The commissioner may suspend or revoke the license of an administrator or impose a fine not to exceed five thousand dollars per violation or twenty-five thousand dollars in the aggregate, if the commissioner finds any of the following as to the administrator:

(1) Has violated any lawful rule or order of the commissioner or any provision of the insurance laws of this state.

(2) Has refused to be examined or to produce its accounts, records, and files for examination or if any of its officers has refused to give information with respect to its affairs or has refused to perform any other legal obligations as to such examination, when required by the commissioner.

(3) Has, without just cause, refused to pay proper claims or perform services arising under its contracts or has, without just cause, caused covered individuals to accept less than the amount due them or caused covered individuals to employ attorneys or bring suit against the administrator to secure full payment or settlement of such claims.

(4) Is affiliated with or under the same general management or interlocking directorate or ownership as another administrator or insurer which unlawfully transacts business in this state without having a certificate of authority.

(5) At any time fails to meet any qualification for which issuance of the license could have been refused had such failure then existed and been known to the commissioner.

(6) Has been convicted of, or has entered a plea of guilty or nolo contendere to, a felony without regard to whether adjudication was withheld.

(7) Is under suspension or revocation in another state.

C. The commissioner may, in his or her discretion and without advance notice or hearing thereon, immediately suspend the certificate of any administrator if the commissioner finds that either of the following circumstances exist:

(1) A proceeding for receivership, conservatorship, rehabilitation, or other delinquency proceeding regarding the administrator has been commenced in any state.

(2) The financial condition or business practices of the administrator otherwise pose an imminent threat to the public health, safety, or welfare of the residents of this state.

Acts 1993, No. 144, §1; Acts 1996, 1st Ex. Sess., No. 71, §1, eff. May 10, 1996.

§3045. Rules and regulations

The commissioner may adopt those rules and regulations as are necessary to implement this Chapter.

Acts 1993, No. 144, §1.

§3046. Confidentiality; documents, information

All information, documents, and copies thereof obtained by or disclosed to the commissioner, or its duly authorized representative, shall be given confidential treatment, shall not be subject to subpoena, and shall not be made public by the commissioner, the National Association of Insurance Commissioners (NAIC), or any other person, except to the insurance departments of other states or in any adjudicatory hearing or court proceeding invoked by the commissioner in accordance with the provisions of this Chapter.

Acts 1993, No. 144, §1.

CHAPTER 6. FINANCIAL INSTITUTION SALES

§3051. Short title

This Chapter may be cited as the "Financial Institution Insurance Sales Law".

Acts 1997, No. 1475, §2, eff. July 15, 1997.

§3052. Purpose

The legislature hereby declares that the purpose of this Chapter is to regulate the business of insurance in Louisiana and to protect the interests of insurance policyholders in this state.

Acts 1997, No. 1475, §2, eff. July 15, 1997.

§3053. Definitions

A. For the purposes of this Chapter:

(1) "Financial institution" means a state or national bank or branch thereof which accepts federally insured deposits or makes loans from a place of business located in the state of Louisiana or any subsidiary or employee thereof, or a bank holding company or subsidiary or employee thereof, only if the bank holding company owns or controls a state or national bank or branch thereof which accepts federally insured deposits or makes loans from a place of business located in the state of Louisiana. The term financial institution does not include a bank which was engaged as an insurance agent on January 1, 1984, or an insurance company.

(2) The term "insurance" includes all products defined or regulated as insurance.

(3) "Insurance company" means a company that possesses a certificate of authority to transact insurance business in this state.

(4) "Person" means any natural person, partnership, corporation, association, business, trust, unincorporated organization, or other form of business enterprise, plural or singular, as the case demands.

Acts 1997, No. 1475, §2, eff. July 15, 1997; Acts 2004, No. 350, §1.

§3053.1. Applicability

The provisions of this Chapter shall not apply to the following:

(1) Any credit insurance, a specialized form of insurance designed to protect the bank's or borrower's interests in loan transactions, including but not limited to credit life insurance, credit dismemberment insurance, credit health and accident insurance, mortgage life and disability insurance, involuntary unemployment insurance, collateral protection insurance, vendor's single interest insurance, travel accident and baggage insurance, and debt cancellation insurance, but credit insurance shall not include vehicle liability and fire and extended coverage as defined in R.S. 22:6 when marketed to borrowers or others.

(2) Insurance placed by a financial institution in connection with collateral pledged as security for a loan when the debtor breaches the contractual obligation to provide that insurance.

(3) Private mortgage insurance.

(4) Annuities.

(5) Title insurance.

Added by Acts 2004, No. 350, §1.

§3054. Authorization for implementing regulations

The commissioner of insurance shall have the authority to promulgate rules and regulations in accordance with the authority granted by the Administrative Procedure Act as may be necessary to effectuate the provisions of this Chapter. However, the commissioner of insurance shall not impose any additional requirement on any insurance agent or broker who is associated with a financial institution that is not imposed on any insurance agent who is not associated with such institution unless such requirement is set forth in this Chapter.

Acts 1997, No. 1475, §2, eff. July 15, 1997.

§3055. Licensure requirement

Any solicitation for the purchase or sale of any insurance product by any person, including a financial institution, its employees or agents, shall be conducted only by persons who have complied with all applicable state insurance licensing and appointment laws and regulations.

Acts 1997, No. 1475, §2, eff. July 15, 1997.

§3056. Sales force

The solicitation of a customer of a financial institution for the purchase or sale of insurance shall not be conducted by any natural person directly responsible for making a specific loan or extension of credit to that customer before such time as the final decision regarding the acceptance or denial of that specific loan or extension of credit is made and communicated in writing to the customer. For the purposes of this Chapter, solicitation does not include referral of the customer to a licensed insurance agent not directly responsible for making the specific loan or extension of credit, informing the customer that the required insurance is available from the financial institution, or providing the customer with any disclosures which are required by R.S. 22:3059.

Acts 1997, No. 1475, §2, eff. July 15, 1997.

§3057. Referrals

A. Any person who is not licensed to sell insurance may refer a customer to a person, or the telephone number of a person, who sells or provides opinions or advice on any insurance product.

B. Any compensation received by the person making a referral provided for in Subsection A of this Section shall not be in the form of a sales commission and shall not be based on the application by the customer or purchase of insurance.

C. No person directly responsible for making a specific loan or extension of credit shall receive any compensation for referral of a customer who is required to provide insurance in connection with that loan or extension of credit.

Acts 1997, No. 1475, §2, eff. July 15, 1997.

§3058. Insurance as a condition to service

A. A financial institution shall not in any manner extend credit, lease, or sell property of any kind, or furnish any service, or fix or vary the consideration for any of the foregoing, on the condition or requirement that the customer shall obtain insurance from the financial institution. In accordance with the foregoing, the financial institution shall not represent that the purchase of an insurance product from a financial institution by a customer or prospective customer of the institution is required as a condition of, or is any way related to, the lending of money or extension of credit, the establishment or maintenance of a trust account, the establishment or maintenance of a checking, savings, or deposit account, or the provision of services related to any such activities.

B. No financial institution shall offer an insurance product in combination with banking products unless the insurance products and banking products are available separately from the institution.

C. The following activities conducted in accordance with the provisions of this Chapter shall not violate the provisions of this Section:

(1) A financial institution may cross-sell or cross-market its products and services by informing customers that insurance is available from the financial institution.

(2) A financial institution that requires a customer to obtain insurance coverage in connection with a loan or other extension of credit may provide the insurance.

Acts 1997, No. 1475, §2, eff. July 15, 1997.

§3059. Disclosures; required

A. At the time a written application for insurance is made, the financial institution shall obtain a separate written statement, signed by the customer, acknowledging that the customer has received and understands the following disclosures:

(1) - (3) REPEALED BY ACTS 2004, No. 350, §2.

(4) The customer is not required to purchase insurance through the financial institution, and the customer's choice of another insurance provider will not affect the financial institution's credit decision or credit terms in any way.

B. The financial institution shall give the customer the disclosures provided in Subsection A of this Section when it first informs the customer that required insurance is available from the financial institution if:

(1) Insurance is required in order to obtain a loan.

(2) Loan approval is contingent on the customer's obtaining acceptable insurance.

(3) The customer obtained insurance required in connection with the loan from another insurance provider and the financial institution is soliciting the sale of insurance to replace the customer's existing coverage.

C. REPEALED BY ACTS 2004, No. 350, §2.

Acts 1997, No. 1475, §2, eff. July 15, 1997; Acts 2004, No. 350, §2.

§3060. Physical location of loan and insurance activities

If the financial institution solicits the purchase of insurance from a customer who is applying for a loan or extension of credit, the insurance solicitation shall be conducted in an area physically separate and distinct from the loan transaction, unless the size of the facility is too small to make the physical separation possible.

Acts 1997, No. 1475, §2, eff. July 15, 1997.

§3061. Insurance in connection with a loan

A. If insurance is required as a condition of obtaining a loan, the credit and insurance transactions shall be completed independently and through separate documents.

B. A loan for premiums on required insurance shall not be included in the primary credit without the written consent of the customer.

C. This Section shall not apply to a premium finance loan that is not made in connection with another loan or extension of credit.

Acts 1997, No. 1475, §2, eff. July 15, 1997.

§3062. No discrimination against non-affiliated agents

No financial institution may:

(1) Offer a banking product or service, or fix or vary the conditions of such offer, on a condition or requirement that the customer obtain insurance from any particular agent or broker.

(2) In connection with a loan or extension of credit that requires a borrower to obtain insurance, reject an insurance policy solely because such policy has been issued or underwritten by any person who is not associated with such institution.

(3) Impose any unreasonable requirement on any insurance agent or broker who is not associated with the financial institution that is not imposed on any insurance agent who is associated with such institution.

Acts 1997, No. 1475, §2, eff. July 15, 1997.

§3063. Customer privacy; protections

A. As used in this Section, unless the context requires otherwise:

(1) "Customer" means a person with an investment security, deposit, trust, or credit relationship with a financial institution.

(2) "Nonpublic customer information" means information maintained by a financial institution relating to insurance coverage purchased by a customer from an insurer, insurance agency, or insurance agent that is not affiliated with the financial institution. "Nonpublic customer information" does not include customer names, addresses and telephone numbers, or any information relating to deposit or investment accounts, loans, or other extensions of credit, or the credit history or financial condition of a customer. Nonpublic customer information includes information concerning insurance escrow accounts, insurance premiums, the terms and conditions of insurance coverage, insurance expirations, insurance claims, and insurance history of an individual, when such information relates to insurance coverage purchased by a customer from an insurer, insurance agency, or insurance agent that is not affiliated with that financial institution.

B. No person shall use any nonpublic customer information for the purpose of selling or soliciting the purchase of insurance or provide nonpublic customer information to a third party for the purpose of another's sale or solicitation of the purchase of insurance, unless it is clearly and conspicuously disclosed that the information may be so used, and the customer has provided prior written consent to the use for this purpose.

C. The consent under Subsection B of this Section shall be obtained in a separate document and shall not be required as a condition for performance of other services for the customer.

Acts 1997, No. 1475, §2, eff. July 15, 1997.

§3064. REPEALED BY ACTS 2004, No. 350, §2.

§3065. Unfair trade practice

Failure to comply with any of the provisions of this Chapter shall be an unfair method of competition and an unfair or deceptive act or practice subject to regulation by the commissioner of insurance as provided by law, including R.S. 22:1142 and 1215 through 1219.

Acts 1997, No. 1475, §2, eff. July 15, 1997, H.C.R. No. 4, 2002 1st Ex. Sess.

CHAPTER 7. MEDICAL NECESSITY REVIEW ORGANIZATIONS

§3070. Legislative findings; purpose; short title

A. Without standards for entities that determine the medical necessity of health care services, Louisianians may face unreasonable delays or denials of requests for coverage from their health benefit plans.

B. Health insurance issuers are not authorized by law to engage in the practice of medicine or adopt administrative treatment guidelines that impinge upon or encumber the independent medical judgment of treating physicians or health care providers.

C. Only entities that are licensed to practice medicine or otherwise authorized by law to determine what medical services or procedures are medically necessary for an individual should be allowed to make medical necessity determinations.

D. The purpose of this Chapter is to establish the minimum standards required for any entity that determines what medical services or procedures will be covered under a health benefit plan based on medical necessity.

E. This Chapter shall be known and may be cited as the "Medical Necessity Review Organization Act".

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3071. Definitions

As used in this Chapter, the following terms shall be defined as follows:

(1) "Adverse determination" means a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and denied, reduced, or terminated by a reviewer based on medical necessity, appropriateness, health care setting, level of care, or effectiveness.

(2) "Ambulatory review" means review of health care services performed or provided in an outpatient setting.

(3) "Appropriate medical information" means all outpatient and inpatient medical records that are pertinent to the evaluation and management of the covered person and that permit the Medical Necessity Review Organization to determine compliance with the applicable clinical review criteria. In the review of coverage for particular services, these records may include but are not necessarily limited to one or more of the following portions of the covered person's medical records as they relate directly to the services under review for medical necessity: admission history and physical examination report, physician's orders, progress notes, nursing notes, operative reports, anesthesia records, hospital discharge summary, laboratory and pathology reports, radiology or other imaging reports, consultation reports, emergency room records, and medication records.

(4) "Authorized representative" means a person to whom a covered person has given written consent to represent the covered person in an internal or external review of an adverse determination of medical necessity. "Authorized representative" may include the covered person's treating provider if the covered person appoints the provider as his authorized representative and the provider waives in writing any right to payment from the covered person other than any applicable copayment or coinsurance amount. In the event that the service is determined not to be medically necessary, and the covered person or his authorized representatives thereafter requests the services, nothing shall prohibit the provider from charging usual and customary charges for all nonmedically necessary services provided.

(5) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

(6) "Certification" or "certify" means a determination by a reviewer regarding coverage of an admission, continued stay, or other health care service for the purpose of determining medical necessity, appropriateness of the setting, or level of care.

(7) "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review.

(8) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a reviewer to determine the necessity and appropriateness of covered health care services.

(9) "Commissioner" means the commissioner of insurance.

(10) "Concurrent review" means a review of medical necessity, appropriateness of care, or level of care conducted during a patient's stay or course of treatment.

(11) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(12) "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

(13) "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

(14) "Disclose" means to release, transfer, or otherwise divulge protected health information to any individual, entity, or person other than the individual who is the subject of the protected health information.

(15) "Emergency medical condition" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) Placing the health of the individual in serious jeopardy.

(b) With respect to a pregnant woman, placing the health of the woman or her unborn child in serious jeopardy.

(c) Serious impairment to bodily function.

(d) Serious dysfunction of any bodily organ or part.

(16) "Entity" means an individual, person, corporation, partnership, association, joint venture, joint stock company, trust, unincorporated organization, any similar entity, agent, or contractor, or any combination of the foregoing.

(17) "External review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations and whose accreditation or certification has been reviewed and approved by the Department of Insurance.

(18) "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing facilities, inpatient hospice facilities, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

(19) "Final adverse determination" means an adverse determination that has been upheld by a reviewer at the completion of the medical necessity review organization's internal review process as set forth in this Chapter.

(20) "Health benefit plan" means group and individual health insurance coverage, coverage provided under a group health plan, or coverage provided by a nonfederal governmental plan, as those terms are defined in R.S. 22:250.1. "Health benefit plan" shall not include a plan providing coverage for excepted benefits as defined in R.S. 22:250.1(3).

(21) "Health care professional" means a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law.

(22) "Health care provider" or "provider" means a health care professional or a facility.

(23) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(24) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relate to any of the following:

(a) The past, present, or future physical, mental, or behavioral health or condition of a covered person or a member of the covered person's family.

(b) The provision of health care services to a covered person.

(c) Payment for the provision of health care services to a covered person.

(25) "Health insurance coverage" means benefits consisting of medical care provided or arranged for directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer.

(26) "Health insurance issuer" means an insurance company, including a health maintenance organization as defined and licensed pursuant to Part XII of Chapter 2 of this Title, unless preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974.

(27) "Medical Necessity Review Organization" or "MNRO" means a health insurance issuer or other entity licensed or authorized pursuant to this Chapter to make medical necessity determinations for purposes other than the diagnosis and treatment of a medical condition.

(28) "Prospective review" means a review conducted prior to an admission or a course of treatment.

(29) "Protected health information" means health information that either identifies a covered person who is the subject of the information or with respect to which there is a reasonable basis to believe that the information could be used to identify a covered person.

(30) "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but shall not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

(31) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.

(32) "Working day" means Monday through Friday, excluding holidays and days upon which an emergency has been declared by state or local government authorities, on which days an MNRO is not able to conduct business in a normal manner.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Acts 2003, No. 1109, §1.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3072. Authorization or licensure as an MNRO

A. No health insurance issuer shall act as an MNRO for the purpose of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar medical determinations unless authorized as an MNRO by the commissioner as provided in this Chapter.

B. No entity acting on behalf of or as the agent of a health insurance issuer may act as an MNRO for the purpose of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar determinations unless licensed as an MNRO by the commissioner as provided in this Chapter.

C. Any other entity may apply for and be issued a license under this Chapter to act as an MNRO for the purposes of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar determinations on behalf of a health benefit plan.

D. Any entity licensed as an MNRO shall be exempt from the requirements of R.S. 40:2721 through 2736.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3073. Procedure for application to act as an MNRO

A. Any applicant for licensure other than a health insurance issuer shall submit an application to the commissioner and pay the initial licensure fee specified in R.S. 22:3074(D). The application shall be on a form and accompanied by any supporting documentation required by the commissioner and shall be signed and verified by the applicant. The information required by the application shall include but need not be limited to the following:

(1) The name of the entity operating as an MNRO and any trade or business names used by that entity in connection with making medical necessity determinations.

(2) The names and addresses of every officer and director of the entity operating as an MNRO, as well as the name and address of the corporate officer designated by the MNRO as the corporate representative to receive, review, and resolve all grievances addressed to the MNRO.

(3) The name and address of every person owning, directly or indirectly, five percent or more of the entity operating as an MNRO.

(4) The principal place of business of the MNRO.

(5) A general description of the operation of the MNRO which includes a statement that the MNRO does not engage in the practice of medicine or act to impinge or encumber the independent medical judgement of treating physicians or health care providers.

(6) A copy of the MNRO's procedures manual which meets the requirements of this Chapter for making medical necessity determinations and resolving disputes on an internal and external basis.

(7) A sample copy of any contract, absent fees charged, with a health insurance issuer, nonfederal government health benefit plan, or other group health plan for making determinations of medical necessity.

(8) The names, addresses, and qualifications of individuals being designated to make adverse medical necessity determinations pursuant to this Chapter.

B. A health insurance issuer holding a valid certificate of authority to operate in this state may be authorized to act as an MNRO under the requirements of this Chapter following submission to the commissioner of appropriate documentation for review and approval that shall include but need not be limited to the following:

(1) A general description of the operation of the MNRO which includes a statement that the MNRO does not engage in the practice of medicine or act to impinge upon or encumber the independent medical judgement of treating physicians or health care providers.

(2) A copy of the MNRO's program description or procedures manual which meets the requirements of this Chapter for making medical necessity determinations and resolving disputes on an internal and external basis.

(3) A sample copy of any contract, absent fees charged, with another health insurance issuer for making determinations of medical necessity.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3074. Expiration and renewal of license for entities other than health insurance issuers

A. Licensure pursuant to this Chapter shall expire two years from the date approved by the commissioner unless the license is renewed for a two-year term as provided in this Section.

B. Before a license expires, it may be renewed for an additional two-year term if the applicant pays a renewal fee as provided in this Section and submits to the commissioner a renewal application on the form that the commissioner requires.

C. The renewal application required by the commissioner shall include but need not be limited to the information required for an initial application that has changed.

D. The fee for initial licensure and the fee for renewal of licensure shall each be one thousand five hundred dollars.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Acts 2003, No. 1109, §1.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3075. Scope and content of medical necessity determination process

A. An MNRO shall implement a written medical necessity determination program that describes all review activities performed for one or more health benefit plans. The program shall include the following:

(1) Methodology to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services.

(2) Data sources and clinical review of criteria used in decision-making.

(3) The process for conducting appeals of adverse determinations.

(4) Mechanisms to ensure consistent application of review criteria and compatible decisions.

(5) Data collection processes and analytical methods used in assessing utilization of health care services.

(6) Provisions for assuring confidentiality of clinical and proprietary information.

(7) The organizational structure, including any review panel or committee, quality assurance committee, or other committee that periodically accesses health care review activities and reports to the health benefit plan.

(8) The medical director's responsibilities for day-to-day program management.

(9) Any quality management program utilized by the MNRO.

B. An MNRO shall file with the commissioner an annual summary report of its review program activities that includes a description of any substantive changes that have been implemented since the last annual report.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3076. Medical necessity review organization operational requirements

A. An MNRO shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. An MNRO may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors. An MNRO shall make available its clinical review criteria upon request to the commissioner who shall be authorized to request affirmation of such criteria from other appropriate state regulatory agencies.

B. An MNRO shall have a medical director who shall be a duly licensed physician. The medical director shall administer the program and oversee all review decisions. Adverse determinations shall be made only by a duly licensed physician or clinical peer. An adverse determination made by an MNRO in the second level review shall become final only when a clinical peer has evaluated and concurred with such determination.

C. An MNRO shall issue determination decisions in a timely manner pursuant to the requirements of this Chapter. At the time of the request for review, an MNRO shall notify the covered person or his authorized representative and the provider of all documentation required to make a medical review determination. In the event that the MNRO determines that additional information is required, it shall notify the covered person or his authorized representative and the provider, by telephone, within one work day of such determination, to request any additional appropriate medical information required. An MNRO shall obtain all information required to make a medical necessity determination, including pertinent clinical information, and shall have a process to ensure that qualified health care professionals performing medical necessity determinations apply clinical review criteria consistently.

D. At least annually, an MNRO shall routinely assess the effectiveness and efficiency of its medical necessity determination program and report any deficiencies or changes to the commissioner.

E. An MNRO's data systems shall be sufficient to support review program activities and to generate management reports to enable the health benefit plan to monitor its activities.

F. Health insurance issuers who delegate any medical necessity determination functions to an MNRO shall be responsible for oversight, which shall include the following:

(1) A written description of the MNRO's activities and responsibilities, including reporting requirements.

(2) Evidence of formal approval of the medical necessity determination program by the health insurance issuer.

(3) A process by which the health insurance issuer monitors or evaluates the performance of the MNRO.

G. Health insurance issuers who perform medical necessity determinations shall coordinate such program with other medical management activities conducted by the health insurance issuer, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction, and risk management.

H. An MNRO shall provide health care providers with access to its review staff by a toll-free number that is operational for any period of time that an authorization, certification, or approval of coverage is required.

I. When conducting medical necessity determinations, the MNRO shall collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency, and duration of services.

J. Compensation to individuals participating in a medical necessity determination program shall not contain incentives, direct or indirect, for those individuals to make inappropriate review determinations. Compensation to any such individuals shall not be based, directly or indirectly, on the quantity or type of adverse determinations rendered.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3077. Procedures for making medical necessity determinations

A. An MNRO shall maintain written procedures for making determinations and for notifying covered persons and providers and other authorized representatives acting on behalf of covered persons of its decisions.

B.(1) In no less than eighty percent of initial determinations, an MNRO shall make the determination within two working days of obtaining any appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. In no instance shall any determination of medical necessity be made later than thirty days from receipt of the request unless the patient's physician or other authorized representative has agreed to an extension.

(2) In the case of a determination to certify a nonemergency admission, procedure, or service, the MNRO shall notify the provider rendering the service within one work day of making the initial certification and shall provide documented confirmation of such notification to the provider within two working days of making the initial certification.

(3) In the case of an adverse determination of a nonemergency admission, the MNRO shall notify the provider rendering the service within one work day of making the adverse determination and shall provide documented confirmation of the notification to the provider within two working days of making the adverse determination.

C.(1) For concurrent review determinations of medical necessity, an MNRO shall make such determinations within one working day of obtaining the results of appropriate medical information that may be required.

(2) In the case of a determination to certify an extended stay or additional services, the MNRO shall notify the provider rendering the service, whether a health care professional or facility or both, and the covered person receiving the service within one working day of making the certification. A copy or telefacsimile of the certification delivered to the provider and addressed to the covered person shall be deemed full compliance with the requirement to notify the covered person. The MNRO shall also provide documented confirmation to the provider within two working days of the authorization. Such documented notification shall include the number of intended days or next review date and the new total number of days or services approved.

(3) In the case of an adverse determination, the MNRO shall notify the provider rendering the service, whether a health care professional or facility or both, and the covered person receiving the service within one working day of making the adverse determination. A copy or telefacsimile of the adverse determination delivered to the provider and addressed to the covered person shall be deemed full compliance with the requirement to notify the covered person. The MNRO shall also provide documented notification to the provider within one work day of such notification. The service shall be authorized and payable by the health insurance issuer without liability, subject to the provisions of the policy or subscriber agreement, until the provider has been notified of the adverse determination. The covered person shall not be liable for the cost of any services delivered following documented notification to the provider unless notified of such liability in advance.

D.(1) For retrospective review determinations, the MNRO shall make the determination within thirty working days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred eighty days from the date of service. The MNRO shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon prior approval, unless the approval was based upon a material omission or misrepresentation about the covered person's health condition made by the provider or unless the coverage was duly canceled for fraud or nonpayment of premiums.

(2) In the case of an adverse determination, the MNRO shall notify in writing the provider rendering the service and the covered person within five working days of making the adverse determination.

E. A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. An MNRO shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who follows the procedures.

F. An MNRO shall have written procedures listing the information required from a covered person or health care provider in order to make a medical necessity determination. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall also outline the process to be followed in the event that the MNRO determines the need for additional information not initially requested.

G. An MNRO shall have written procedures to address the failure or inability of a provider or a covered person to provide all necessary information for review. In cases where the provider or a covered person will not release necessary information, the MNRO may deny certification.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000; Acts 2001, No. 778, §1.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3078. Informal reconsideration

A. In a case involving an initial determination or a concurrent review determination, an MNRO shall give the provider rendering the service an opportunity to request on behalf of the covered person an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination. Allowing a ten-day period following the date of the adverse determination for requesting an informal reconsideration shall be considered reasonable.

B. The informal reconsideration shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the MNRO's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one working day.

C. If the informal reconsideration process does not resolve the differences of opinion, the adverse determination may be appealed by the covered person or the provider on behalf of the covered person. Informal reconsideration shall not be a prerequisite to a standard appeal or an expedited appeal of an adverse determination.

Acts 1999, No. 401, §1; Acts 2004, No. 450, §1.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3079. Appeals of adverse determinations; standard appeals

A. An MNRO shall establish written procedures for a standard appeal of an adverse determination, which may also be known as a first level internal appeal. Such procedures shall be available to the covered person and to the provider acting on behalf of the covered person. Such procedures shall provide for an appropriate review panel for each appeal that includes health care professionals who have appropriate expertise.

B. For standard appeals, a duly licensed physician shall be required to concur with any adverse determination made by the review panel.

C. The MNRO shall notify in writing both the covered person and the attending or ordering provider of the decision within thirty working days following the request for an appeal, unless the covered person or authorized representative and the MNRO mutually agree that a further extension of the time limit would be in the best interest of the covered person. The written decision shall contain the following:

(1) The title and qualifying credentials of the physician affirming the adverse determination.

(2) A statement of the reason for the covered person's request for an appeal.

(3) An explanation of the reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the MNRO's position.

(4) If applicable, a statement including the following:

(a) A description of the process to obtain a second level review of a decision.

(b) The written procedures governing a second level review, including any required time frame for review.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3080. Second level review

A. An MNRO shall establish a second level review process to give covered persons who are dissatisfied with the first level review decision the option to request a review at which the covered person has the right to appear in person before authorized representatives of the MNRO. An MNRO shall provide covered persons with adequate notice of this option.

B. An MNRO shall conduct a second level review for each appeal. Appeals shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer shall not have been involved in the initial adverse determination. A majority of any review panel used shall be comprised of persons who were not previously involved in the appeal. However, a person who was previously involved with the appeal may be a member of the panel or appear before the panel to present information or answer questions. The panel shall have the legal authority to bind the MNRO and the health benefit plan to the panel's decision.

C. An MNRO shall ensure that a majority of the persons reviewing a second level appeal are health care professionals who have appropriate expertise. An MNRO shall issue a copy of the written decision to a provider who submits an appeal on behalf of a covered person. In cases where there has been a denial of service, the reviewing health care professional shall not have a financial incentive or interest in the outcome of the review.

D. The procedures for conducting a second level review shall include the following:

(1) The review panel shall schedule and hold a review meeting within forty-five working days of receiving a request from a covered person for a second level review. The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person. In cases where a face-to-face meeting is not practical for geographic reasons, an MNRO shall offer the covered person the opportunity to communicate with the review panel, at the MNRO's expense, by conference call, video conferencing, or other appropriate technology. The covered person shall be notified of the time and place of the review meeting in writing at least fifteen working days in advance of the review date; such notice shall also advise the covered person of his rights as specified in Paragraph (3) of this Subsection. The MNRO shall not unreasonably deny a request for postponement of a review meeting made by a covered person.

(2) Upon the request of a covered person, an MNRO shall provide to the covered person all relevant information that is not confidential or privileged.

(3) A covered person shall have the right to the following:

(a) Attend the second level review.

(b) Present his case to the review panel.

(c) Submit supporting material both before and at the review meeting.

(d) Ask questions of any representative of the MNRO.

(4) The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.

(5) For second level appeals, a duly licensed and appropriate clinical peer shall be required to concur with any adverse determination made by the review panel.

(6) The MNRO shall issue a written decision to the covered person within five working days of completing the review meeting. The decision shall include the following:

(a) The title and qualifying credentials of the appropriate clinical peer affirming an adverse determination.

(b) A statement of the nature of the appeal and all pertinent facts.

(c) The rationale for the decision.

(d) Reference to evidence or documentation used in making that decision.

(e) The instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination.

(f) Notice of the covered person's right to an external review.

E. An MNRO may establish a procedure that requires that a health care provider pay the cost of a second level appeal when all of the following occur:

(1) The health care provider has made the appeal on behalf of a covered person.

(2) The result of the second level appeal is that the MNRO's previous adverse determination is upheld.

(3) The MNRO's records indicate a consistent practice by the health care provider of requesting second level reviews in an extremely high percentage of cases that were not warranted by available medical information.

(4) The commissioner approves the MNRO's action to require payment by the health care provider.

Acts 1999, No. 401, §1; Acts 2004, No. 450, §1.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3081. Request for external review

A. Each health benefit plan shall provide an independent review process to examine the plan's coverage decisions based on medical necessity. A covered person, with the concurrence of the treating health care provider, may make a request for an external review of a second level appeal adverse determination.

B. Except as provided in this Subsection, an MNRO shall not be required to grant a request for an external review until the second level appeal process as set forth in this Chapter has been exhausted. A request for external review of an adverse determination may be made before the covered person has exhausted the MNRO's appeal, if any of the following circumstances apply:

(1) The covered person has an emergency medical condition.

(2) The MNRO agrees to waive the requirements for the first level appeal, the second level appeal, or both.

C. If the requirement to exhaust the MNRO's appeal procedures is waived under Paragraph B(1) of this Section, the covered person's treating health care provider may request an expedited external review. If the requirement to exhaust the MNRO's appeal procedures is waived under Paragraph B(2) of this Section, a standard external review shall be performed.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3082. Standard external review

A. Within sixty days after the date of receipt of a notice of a second level appeal adverse determination, the covered person whose medical care was the subject of such determination may, with the concurrence of the treating health care provider, file a request for an external review with the MNRO. Within seven days after the date of receipt of the request for an external review, the MNRO shall provide the documents and any information used in making the second level appeal adverse determination to its designated independent review organization. The independent review organization shall review all of the information and documents received and any other information submitted in writing by the covered person or the covered person's health care provider. The independent review organization may consider the following in reaching a decision or making a recommendation:

(1) The covered person's pertinent medical records.

(2) The treating health care professional's recommendation.

(3) Consulting reports from appropriate health care professionals and other documents submitted by the MNRO, covered person, or the covered person's treating provider.

(4) Any applicable generally accepted practice guidelines, including but not limited to those developed by the federal government or national or professional medical societies, boards, and associations.

(5) Any applicable clinical review criteria developed exclusively and used by the MNRO that are within the appropriate standard for care, provided such criteria were not the sole basis for the decision or recommendation unless the criteria had been reviewed and certified by the appropriate licensing board of this state.

B. The independent review organization shall provide notice of its recommendation to the MNRO, the covered person or his authorized representative, and the covered person's health care provider within thirty days after the date of receipt of the second level determination information subject to an external review, unless a longer period is agreed to by all parties.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3083. Expedited appeals

A. An MNRO shall establish written procedures for the expedited appeal of an adverse determination involving a situation where the time frame of the standard appeal would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. An expedited appeal shall be available to and may be initiated by the covered person, with the consent of the treating health care professional, or the provider acting on behalf of the covered person.

B. Expedited appeals shall be evaluated by an appropriate clinical peer or peers in the same or a similar specialty as would typically manage the case under review. The clinical peer or peers shall not have been involved in the initial adverse determination.

C. An MNRO shall provide an expedited appeal to any request concerning an admission, availability of care, continued stay, or health care service for a covered person or his authorized representative who has received emergency services but has not been discharged from a facility.

D. In an expedited appeal, all necessary information, including the MNRO's decision, shall be transmitted between the MNRO and the covered person, or his authorized representative, or the provider acting on behalf of the covered person by telephone, telefacsimile, or any other available expeditious method.

E. In an expedited appeal, an MNRO shall make a decision and notify the covered person or the provider acting on behalf of the covered person as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two hours after the appeal is commenced. If the expedited appeal is a concurrent review determination, the service shall be authorized and payable, subject to the provisions of the policy or subscriber agreement, until the provider has been notified of the determination. The covered person shall not be liable for the cost of any services delivered following documented notification to the provider until documented notification of such liability is provided to the covered person.

F. An MNRO shall provide written confirmation of its decision concerning an expedited appeal within two working days of providing notification of that decision if the initial notification was not in writing. The written decision shall contain the information specified in R.S. 22:3079(C)(1) through (3).

G. An MNRO shall provide reasonable access, within a period of time not to exceed one work day, to a clinical peer who can perform the expedited appeal.

H. In any case where the expedited appeal process does not resolve a difference of opinion between the MNRO and the covered person or the provider acting on behalf of the covered person, such provider may request a second level appeal of the adverse determination.

I. An MNRO shall not provide an expedited appeal for retrospective adverse determinations.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3084. Expedited external review

A. At the time that a covered person receives an adverse determination involving an emergency medical condition of the covered person, the covered person's health care provider may request an expedited external review.

B. For emergency medical conditions, the MNRO shall provide or transmit all necessary documents and information used in making the adverse determination to the independent review organization by telephone, telefacsimile, or any other available expeditious method.

C. In addition to the documents and information provided or transmitted, the independent review organization may consider the following in reaching a decision or making a recommendation:

(1) The covered person's pertinent medical records.

(2) The treating health care professional's recommendation.

(3) Consulting reports from appropriate health care professionals and other documents submitted by the MNRO, the covered person, or the covered person's treating provider.

(4) Any applicable generally accepted practice guidelines, including but not limited to those developed by the federal government or national or professional medical societies, boards, and associations.

(5) Any applicable clinical review criteria developed exclusively and used by the MNRO that are within the appropriate standard for care, provided such criteria were not the sole basis for the decision or recommendation, unless the criteria had been reviewed and certified by the appropriate state licensing board of this state.

D. Within seventy-two hours after receiving appropriate medical information for an expedited external review, the independent review organization shall do the following:

(1) Make a decision to uphold or reverse the adverse determination.

(2) Notify the covered person, the MNRO, and the covered person's health care provider of the decision. Such notice shall include the principal reason or reasons for the decision and references to the evidence or documentation considered in making the decision.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3085. Binding nature of external review decisions

A. Coverage for the services required under this Chapter shall be provided subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the plan. Nothing in this Chapter shall be construed to require the plan to pay for services that are not otherwise covered pursuant to the evidence of coverage under the plan or otherwise required under any applicable state or federal law.

B. An external review decision made pursuant to this Chapter shall be binding on the MNRO and on any health insurance issuer or health benefit plan that utilizes the MNRO for making medical necessity determinations.

C. An external review decision shall be binding on the covered person for purposes of determining coverage under a health benefit plan that requires a determination of medical necessity for a medical service to be covered.

D. A covered person or his representatives, heirs, assigns, or health care providers shall have a cause of action for benefits or damages against an MNRO, health insurance issuer, health benefit plan, or independent review organization for any action involving or resulting from a decision made pursuant to this Chapter if the determination or opinion was rendered in bad faith or involved negligence, gross negligence, or intentional misrepresentation of factual information about the covered person's medical condition.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3086. Minimum qualifications for independent review organizations

A. To qualify to conduct external reviews for an MNRO, an independent review organization shall meet the following minimum qualifications:

(1) Develop written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process that include, at a minimum, the following:

(a) Procedures to ensure that external reviews are conducted within the specified time frames and that required notices are provided in a timely manner.

(b) Procedures to ensure the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases.

(c) Procedures to ensure the confidentiality of medical and treatment records and clinical review criteria.

(d) Procedures to ensure that any individual employed by or under contract with the independent review organization adheres to the requirements of this Chapter.

(2) Establish a quality assurance program.

(3) Establish a toll-free telephone service to receive information related to external reviews on a twenty-four-hour-day, seven-day-a-week basis that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours.

B. Any clinical peer reviewer assigned by an independent review organization to conduct external reviews shall be a physician or other appropriate health care provider who meets the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review.

(2) Be knowledgeable about the recommended health care service or treatment through actual clinical experience that may be based on either of the following:

(a) The period of time spent actually treating patients with the same or similar medical condition of the covered person.

(b) The period of time that has elapsed between the clinical experience and the present.

(3) Hold a nonrestricted license in a state of the United States and, in the case of a physician, hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.

(4) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

C. In addition to the requirements of Subsection A of this Section, an independent review organization shall not own or control, be a subsidiary of, in any way be owned or controlled by, or exercise control with a health insurance issuer, health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers.

D. In addition to the other requirements of this Section, in order to qualify to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor the clinical peer reviewer assigned by the independent organization to conduct the external review shall have a material professional, familial, or financial interest with any of the following:

(1) The MNRO that is the subject of the external review.

(2) Any officer, director, or management employee of the MNRO that is the subject of the external review.

(3) The health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review.

(4) The facility at which the recommended health care service or treatment would be provided.

(5) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3087. External review register

A. An MNRO shall maintain written records in the aggregate and by health insurance issuer and health benefit plan on all requests for external review for which an external review was conducted during a calendar year, hereinafter referred to as the "register". For each request for external review, the register shall contain, at a minimum, the following information:

(1) A general description of the reason for the request for external review.

(2) The date received.

(3) The date of each review.

(4) The resolution.

(5) The date of resolution.

(6) The name of the covered person for whom the request for external review was filed.

B. The register shall be maintained in a manner that is reasonably clear and accessible to the commissioner.

C. The register compiled for a calendar year shall be retained for the longer of three years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.

D. The MNRO shall submit to the commissioner, at least annually, a report in the format specified by the commissioner. The report shall include the following for each health insurance issuer and health benefit plan:

(1) The total number of requests for external review.

(2) The number of requests for external review resolved and their resolution.
(3) A synopsis of actions being taken to correct problems identified.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3088. Emergency services

A. When conducting medical necessity determinations for emergency services, an MNRO shall not disapprove emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of such services if a prudent lay person acting reasonably would have believed that an emergency medical condition existed. With respect to care obtained from a noncontracting provider within the service area of a managed care plan, an MNRO shall not disapprove emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of the services if a prudent lay person would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency or if a provision of federal, state, or local law requires the use of a specific provider.

B. If a participating provider or other authorized representative of a health insurance issuer or health benefit plan authorizes emergency services, the MNRO shall not subsequently retract its authorization after the emergency services have been provided or reduce payment for an item, treatment, or service furnished in reliance upon approval, unless the approval was based upon a material omission or misrepresentation about the covered person's health condition made by the provider of emergency services.

C. Coverage of emergency services shall be subject to state and federal laws as well as contract or policy provisions, including copayments or coinsurance and deductibles.

D. For immediately required post-evaluation or post-stabilization services, an MNRO shall provide access to an authorized representative twenty-four hours a day, seven days a week, to facilitate review.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3089. Confidentiality requirements

An MNRO shall annually provide written certification to the commissioner that its program for determining medical necessity complies with all applicable state and federal laws establishing confidentiality and reporting requirements.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3090. Regulations

The commissioner may, after notice and hearing, promulgate such rules and regulations as may be necessary or proper to carry out the provisions of this Chapter. Such rules and regulations shall be promulgated and adopted in accordance with the Administrative Procedure Act.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3091. Examination of MNRO and other parties

A. The commissioner or a member of his staff may make an examination of the affairs of any MNRO or any health insurance issuer authorized to act as an MNRO as often as it is reasonably necessary for the protection of the interest of the people of this state, but not less frequently than once every three years, to determine whether the MNRO is adhering to the requirements of this Chapter.

B. The commissioner shall be authorized to assess health insurance issuers and licensed MNROs for the cost of performing examinations to determine compliance with this Chapter.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

§3092. Fines; cease and desist orders; grounds for suspension or revocation of licensure or certificate of authority

A. Whenever the commissioner has reason to believe that any health insurance issuer or licensed MNRO is not in full compliance with the provisions of this Chapter, he shall notify such person and, after notice and opportunity for hearing pursuant to Part XXIX of Chapter 1 of this Title, subject to Chapter 13-B of Title 49 of the Louisiana Revised Statutes of 1950, the commissioner shall issue and cause to be served an order requiring the health insurance issuer or MNRO to cease and desist from any violation and order any one or more of the following:

(1) Payment of a monetary penalty of not more than twenty-five dollars for each day that a determination was not made within the time frames established by this Chapter.

(2) Payment of a monetary penalty of not more than one thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of one hundred thousand dollars. However, if the health insurance issuer or MNRO knew or reasonably should have known it was in violation of this Chapter, the penalty shall be not more than twenty-five thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of two hundred fifty thousand dollars in any six-month period.

(3) Suspension or revocation of the license of the health insurance issuer's certificate of authority to operate in this state or the license of an MNRO if the health insurance issuer or MNRO knew or reasonably should have known it was in violation of this Chapter.

B. Any health insurance issuer or licensed MNRO who violates a cease and desist order issued by the commissioner pursuant to this Chapter while such order is in effect shall, after notice and opportunity for hearing, be subject at the discretion of the commissioner to any one or more of the following:

(1) A monetary penalty of not more than twenty-five thousand dollars for each and every act or violation, not to exceed an aggregate of two hundred fifty thousand dollars.

(2) Suspension or revocation of the health insurance issuer's certificate of authority to operate in this state or the license of the MNRO to operate in this state.

C. The license of an MNRO or authorization of a health insurance issuer to act as an MNRO shall be suspended or revoked, or, in lieu of such revocation, a fine may be imposed for each separate violation, not to exceed five thousand dollars per violation, or twenty-five thousand dollars in the aggregate, if the commissioner finds that the MNRO has engaged in any of the following:

(1) Using such methods or practices in the conduct of its business so as to render its further determinations of medical necessity in this state hazardous or injurious to covered persons or the public.

(2) Failing to comply with any independent review organization determination within sixty days after the determination has become final.

Acts 1999, No. 401, §1, eff. Jan. 1, 2000.

NOTE: See Acts 1999, No. 401, §2, regarding applicability.

CHAPTER 8. LOUISIANA SAFETY NET HEALTH INSURANCE PROGRAM

§3101. Creation of the Louisiana Safety Net Health Insurance Program

A. There is hereby established the "Louisiana Safety Net Health Insurance Program". The program shall provide for minimal benefit hospital and medical policies, which may be insured by the Office of Group Benefits for employees eligible therefor, and by participating health insurance issuers for all other employers.

B. This Chapter shall be known and may be cited as the "Louisiana Safety Net Health Insurance Program" and be referred to as the "Louisiana Safety Net" or the "program".

Acts 2003, No. 528, §1, eff. June 24, 2003.

§3102. Eligibility

(1) Employees of the state of Louisiana, and political subdivisions thereof, who have not been covered by health insurance for at least one year and are eligible for coverage through the Office of Group Benefits.

(2) Employers who have not offered group health insurance coverage to their employees for at least one year.

(3) Employers who are not eligible under Paragraph (2) of this Section but who employ persons with an annual family income of not more than two hundred percent of the federal poverty level may offer the insurance only to those employees whose family income is not more than two hundred percent of the federal poverty level even if there are employees whose annual family income exceeds two hundred percent of the federal poverty level. For purposes of this Chapter, a family may consist of the employee only, or where applicable, include the spouse or dependents of the employee.

(4) Individuals seeking coverage under an individual health insurance policy.

Added by Acts 2003, No. 528, §1, eff. June 24, 2003; Acts 2004, No. 493, §1, eff. June 25, 2004.

§3103. Participation and requirements

A. Participating health insurance issuers shall offer minimal benefit hospital and medical insurance policies that allow enrollees or insureds access to at least one Prime Network. The Prime Network shall be specifically established for the minimal benefit hospital and medical policies to be offered pursuant to this Chapter. Health insurance issuers may contract directly with health care providers or through a network of providers.

B. Participating health insurance issuers shall offer minimal benefit hospital and medical insurance policies under which the enrollees or insureds shall be entitled to contracted reimbursement rates by contracted health care providers for covered health care services, whether paid for by the health insurance issuer, the enrollee, or the insured.

C. Every insured or enrollee shall at the time of enrollment and annually thereafter be provided with a directory listing of contracted health care providers, denoting whether such contracted health care providers participate in a Prime Network.

D. The health insurance issuer shall issue an identification card that sets forth the name of the health insurance issuer prominently displayed on the face of the identification card and contains the following statement:

"BEFORE YOU SEEK SERVICES FROM A PROVIDER, CONTACT THE HEALTH INSURANCE ISSUER AT THE TOLL-FREE NUMBER LISTED BELOW FOR BENEFITS OR NETWORK CONFIRMATION."

E. Notwithstanding any law to the contrary, minimal benefit hospital and medical policies offered under the program shall be exempt from the provisions of Part VI of Chapter 1 of this Title, R.S. 22:211 et seq., Part VI-C of Chapter 1 of this Title, R.S. 22:250.1 et seq., and all other provisions of this Title, unless otherwise specifically provided herein.

F. Participating health insurance issuers may offer additional insurance products that include but are not limited to:

(1) Group health insurance that utilizes employer or employee funded savings, reimbursement, or personal care accounts in conjunction with the applicable deductible provisions.

(2) Employer funded personal care accounts shall not be taxable to the employee and shall be deductible to the employer, in accordance with applicable federal and state taxation laws.

(3) Minimal benefit hospital and medical insurance plans to employees of the state of Louisiana, and political subdivisions thereof; to the extent authorized by the Office of Group Benefits.

(4) Such additional insurance products as appropriate.

G. Employers that participate in the program shall:

(1) Pay at least fifty percent of the eligible employee premium cost. This provision shall not apply to the Office of Group Benefits.

(2) Enroll at least fifty percent of eligible employees in the program. This provision shall not apply to the Office of Group Benefits.

H. The commissioner may promulgate rules and regulations as may be necessary or proper to carry out the provisions of this Chapter. The commissioner shall issue reasonable regulations to establish specific standards and guidelines for Prime Network policies and certificates. No requirement of this Title relating to minimum required policy benefits, other than the minimum standards contained in this Chapter, shall apply to Prime Network policies. Such standards and guidelines shall address the following:

(1) Advertising and marketing.

(2) Applications and enrollment forms.

(3) Definition of terms.
(4) Form filing requirements and prohibitions.
(5) Policyholder requirements pertaining to individuals, trusts, associations, and employer groups.
(6) Uninsured impact report.
(7) Underwriting requirements relative to adverse selection.

I. For purposes of offering minimal benefits hospital and medical policies under this Chapter, a preferred provider organization shall be exempt from any mandated benefit requirements or mandated provider participation requirements pursuant to R.S. 40:2201 et seq. unless otherwise required by this Chapter.

Added by Acts 2003, No. 528, §1, eff. June 24, 2003; Acts 2004, No. 493, §1, eff. June 25, 2004.

§3104. Plan of operation

A. A health insurance issuer shall submit a plan of operation to the commissioner for review and approval whereby the health insurance issuer establishes policies and procedures:

(1) For the determination of program eligibility of employers, as set forth in R.S. 22:3102.

(2) Relative to the program network criteria, as set forth in R.S. 22:3103, and which shall contain at least the following:

(a) Evidence that all covered Prime Network services are available and accessible through Prime Network providers, including demonstration that:

(i) Covered Prime Network services can be provided by Prime Network providers with reasonable promptness with respect to geographic location, hours of operation, and availability of after hour care. The hours of operation and availability of after hour care shall reflect usual practice in the local area. Geographic availability shall reflect usual practice in the community.

(ii) The number of Prime Network providers in the service area is sufficient, with respect to current and expected policyholders.

(iii) There are participation agreements with Prime Network providers that contain provisions prohibiting Prime Network providers from billing, collecting, or otherwise seeking reimbursement or recourse against any insured or enrollee, except for applicable amounts representing copayments, coinsurance, deductibles, or noncovered services.

(b) A statement or map providing a clear description of the service area.
(c) A formal description of the formal organization or structure of the health insurance issuer.
(d) The written criteria for selection, retention, and removal of Prime Network providers.
(e) A list and description of Prime Network providers, by specialty, if any.

B.(1) A health insurance issuer shall file any proposed changes to the plan of operation with the commissioner prior to implementing the changes. Changes shall be considered approved by the commissioner after thirty days unless specifically disapproved. The health insurance issuer shall notify the commissioner of any changes of Prime Network providers.

(2) Any updated list of Prime Network providers shall be filed with the commissioner at least quarterly.

(3) A health insurance issuer shall make full and fair disclosure, in writing, of the provisions, restrictions, and limitations of the policy or certificate to each applicant. The disclosure shall include at least the following:

(a) An outline of coverage and itemized benefits.
(b) A description of the rights of the insured or enrollee.

C. The Office of Group Benefits and participating health insurance issuers, respectively, shall be responsible for the administration of the minimal benefit hospital and medical plans or policies, as well as any other insurance products offered pursuant to this program, and shall bear all risk of loss therefor.

Added by Acts 2003, No. 528, §1, eff. June 24, 2003; Acts 2004, No. 493, §1, eff. June 25, 2004.

§3105. Producer requirements

No producer fees or other compensation or consideration shall be payable for coverage offered through the plan unless:

(1) The producer is duly licensed by the commissioner.

(2) The producer certifies to the health insurance issuer in writing, that to the best of his knowledge, the employer is a qualifying employer as required by this Chapter and the producer is required to meet all applicable producer provisions enumerated in this Title.

Added by Acts 2003, No. 528, §1, eff. June 24, 2003; Acts 2004, No. 493, §1, eff. June 25, 2004.

§3106. Form of policy; delivery; cancellation

A. No minimal benefit hospital and medical policy shall be delivered or issued for delivery on risks in this state unless:

(1) The entire money and other consideration therefor are expressed therein.

(2) The time at which the insurance takes effect and terminates is expressed therein.

(3) Every printed portion of the text matter of the policy and of any endorsements or attached papers is printed in type the size of which shall be uniform and the face of which shall be not less than ten point. The "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, captions and subcaptions, and form numbers.

(4) The exceptions and reductions of indemnity are clearly set forth in the policy or contract and are printed, at the insurer's option, either with the benefit to which they apply or under an appropriate caption such as "Exceptions" or "Exceptions and Reductions".

(5) Each such form, including riders and endorsements, shall be identified by a form number in the lower left hand corner of the first page thereof.

(6) There is prominently printed thereon or attached thereto, a notice to the insured that ten days are allowed, from the date of his receipt of the policy, to examine its provisions and if such policy was solicited by deceptive advertising or negotiated by deceptive, misleading, or untrue statements of the insurer or any agent on behalf of the insurer, such policy may be surrendered within said ten-day period and any premium advanced by the insured, upon such surrender, shall be immediately returned to him; provided, that the insurer shall have the option of printing or attaching the notice above required or a notice of equal prominence which, in the opinion of the commissioner of insurance, is not less favorable to the enrollee or insured.

B. If the policy is delivered by a producer, a receipt shall be signed by the enrollee or insured policyholder acknowledging delivery of the policy. The receipt shall include the policy number and the date the delivery was completed. All delivery receipts required by this Subparagraph shall be retained by the insurer, its producer for two consecutive years. The requirement of this Subsection shall not apply to any insurer that markets under a home service marketing distribution method and that issues a majority of its policies on a weekly or monthly basis.

C.(1) If the policy is delivered by mail, it shall be sent by certified mail, return receipt requested, or a certificate of mailing shall be obtained showing the date the policy was mailed to the enrollee or insured policy owner. For policy issuances verified by a certificate of mailing, it is presumed that the policy is received by the enrollee or insured policy owner ten days from the date of mailing. The receipts and the certificate of mailing described in this Section shall be retained by the insurer or producer for three years.

(2) A health insurance issuer or producer may utilize commercial carriers or other commercially recognized carriers to deliver the policy to the enrollee or the insured; however, the health insurance issuer or producer shall maintain documentation of actual delivery of such policy for three years.

(3) The policy or certificate of insurance may be delivered electronically to the enrollee or the insured in accordance with R.S. 9:2608; however, the health insurance issuer and the enrollee or insured shall agree to such electronic delivery, and the documentation of such delivery shall be maintained by the insurer for three years.

D. In any case where the policy is subject to cancellation at the option of the insurer, there shall be prominently printed on the first page of such policy a statement so informing the insured or enrollee policyholder.

Acts 2003, No. 528, §1, eff. June 24, 2003.

§3107. File and use of policy forms

Health insurance issuers shall file with the commissioner minimal benefit hospital and medical plans delivered or issued for delivery in this state. Such forms shall be considered approved, unless notified by the commissioner of insurance within thirty days from the filing thereof. The commissioner shall only be authorized to disapprove such policy forms for the following reasons:

(1) The health insurance issuer is insolvent.

(2) The policy form does not comply with the requirements of R.S. 22:3106 and 3108.

Acts 2003, No. 528, §1, eff. June 24, 2003.

§3108. Minimal benefit hospital and medical policy provisions

A. No minimal benefit hospital and medical policy shall be delivered or issued in this state without the following notice:

"THIS IS A MINIMAL BENEFIT HOSPITAL AND MEDICAL POLICY. THIS IS NOT A COMPREHENSIVE MAJOR MEDICAL POLICY."

B. Each minimal benefit hospital and medical policy shall contain in substance the following provisions or, at the option of the insurer, provisions which in the opinion of the commissioner are not less favorable to the policyholder; provided that, except as permitted by R.S. 22:211(C), no time limitation with respect to the filing of notice or proof of loss or within which suit may be brought upon the policy shall differ from the time limitations of the following provisions:

(1) Entire contract: Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No agent has authority to change this policy or to waive any of its provisions. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto.

(2) All claims arising under the terms of Safety Net policies issued in this state shall be paid not more than thirty days from the date upon which written notice or proof of claim, in the form required by the terms of the policy, is submitted.

(3) Cancellation: The insurer may cancel this policy at any time subject to the provisions of R.S. 22:228 and R.S. 22:636(F). Such cancellation shall be by written notice, delivered to the insured, or mailed to his last address as shown by the records of the insurer, shall refund the pro rata unearned portion of any premium paid, and shall comply with the provisions of R.S. 22:636(F). Such cancellation shall be without prejudice to any claim for benefits accrued or expenses incurred for services rendered prior to cancellation. Benefits and expenses incurred shall be as defined and limited by the terms of the policy. The insured may likewise cancel this policy on the above terms. Upon cancellation by the insurer, however, the insurer shall only be liable for any claim for benefits accrued, or for expenses incurred for services rendered, subsequent to the cancellation date if the subsequent claim is for an illness or condition which was the basis of any claim prior to cancellation and for which the insurer had notice and if the policy of insurance is canceled for reasons other than failure of the policyholder to pay premiums or failure of the insured to maintain eligibility as provided in the policy. Upon the written request of the named insured, the insurer shall provide to the insured in writing the reasons for cancellation of the policy. There shall be no liability on the part of and no cause of action of any nature shall arise against any insurer or its agents, employees, or representatives for any action taken by them to provide the reasons for cancellation as required by this Paragraph. All policies or certificates must contain a grace period of not less than thirty days whenever the health insurance issuer does not receive a premium payment. If default be made in the payment of any agreed premium for this policy, the subsequent acceptance of such defaulted premium by the insurer or by any agent authorized by the insurer to accept such premium shall reinstate the policy, but the reinstated policy shall cover only loss resulting from accidental injury thereafter sustained or loss due to sickness beginning more than ten days after the date of such acceptance.

Added by Acts 2003, No. 528, §1, eff. June 24, 2003; Acts 2004, No. 493, §1, eff. June 25, 2004.

§3109. Construction of policy

A policy issued in violation of this Chapter shall be held valid and shall be construed as provided herein. When any provision in such a policy is in conflict with any provisions of this Chapter, the rights, duties, and obligations of the health insurance issuer, the enrollee and the insured shall be governed by the provisions of this Chapter.

Acts 2003, No. 528, §1, eff. June 24, 2003.

§3110. Statutory construction; relationship to other laws

Except as otherwise provided in this Chapter, provisions of the insurance law and provisions of this Title shall not be applicable to minimal benefit hospital and medical policies, unless as provided in this Chapter.

Acts 2003, No. 528, §1, eff. June 24, 2003.

§3111. Scope and limitation

A. It is not the purpose of this Chapter to alter or diminish any right, privilege, or authority granted to any health insurance issuer to write hospital insurance under any other Chapter, Part, or Section of this Title.

B. All health insurance insurers operating pursuant to a license as required by this Chapter shall be exempt from the applicability of all other insurance laws of this state, except the Unfair Trade Practices provisions of Part XXVI of Chapter 1 of this Title provided intent is established that the health insurance issuer is committing or performing with such frequency such practices as to indicate a general business practice, any financial solvency enumerated in this Chapter, or where such laws are specifically incorporated herein by reference.

Acts 2003, No. 528, §1, eff. June 24, 2003.

§3112. Definitions

As used in this Chapter:

(1) "Commissioner" means the commissioner of insurance.

(2) "Contracted health care provider" means a health care provider that has entered into a contract or agreement directly with a health insurance issuer or through a network of providers for the provision of covered health care services.

(3) "Contracted reimbursement rate" means the aggregate maximum amount that a contracted health care provider has agreed to accept from all sources for provision of covered health care services under the health insurance coverage applicable to the enrollee or insured.

(4) "Covered health care services" means services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease that are either covered and payable under the terms of the health insurance coverage.

(5) "Department" means the Department of Insurance.

(6) "Enrollee" or "insured" means a person, including a spouse or dependent, who is enrolled in or insured by a health insurance issuer for health insurance coverage. A dependent includes unmarried children under twenty-one years of age or, in the case of full-time students, unmarried children under the age of twenty-four, and unmarried grandchildren under twenty-one years of age in the legal custody of and residing with the grandparent or, in the case of full-time students, unmarried grandchildren under the age of twenty-four who are in the legal custody of and residing with the grandparent, except that the policy may provide for continuing coverage for any unmarried child or grandchild in the legal custody of and residing with the grandparent who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, who became so incapable prior to attainment of age twenty-one, and any other person dependent upon the employee. Any unmarried child who is placed in the home of an insured or enrollee pursuant to an adoption placement agreement executed with an adoption agency licensed in accordance with the Child Care Facility and Child-Placing Agency Licensing Act (R.S. 46:1401 et seq.), or corresponding law of any other state, shall be considered a dependent child of the insured from the date of placement in the home of the insured or enrollee.

(7) "Health care facility" means a facility or institution providing health care services including but not limited to a hospital or other licensed inpatient center, ambulatory surgical or treatment center, skilled nursing facility, inpatient hospice facility, residential treatment center, diagnostic, laboratory, or imaging center, or rehabilitation or other therapeutic health setting. A health care facility may also be a base health care facility.

(8) "Health care professional" means a physician or other health care practitioner licensed, certified, or registered to perform specified health care services consistent with state law.

(9) "Health care provider" or "provider" means a health care professional or a health care facility or the agent or assignee of such professional or facility.

(10) "Health care services" means services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(11) "Health insurance coverage" means benefits consisting of medical care provided or arranged for directly, through insurance or reimbursement, or otherwise, and includes health care services paid for under any plan, policy, or certificate of insurance.

(12) "Health insurance issuer" means any entity that offers health insurance coverage through a policy or certificate of insurance subject to state law that regulates the business of insurance. For purposes of this Chapter, a "health insurance issuer" shall include a health maintenance organization, as defined and licensed pursuant to Part XII of Chapter 2 of this Title, and nonfederal government plans subject to the provisions of Part VI-D of Chapter 1 of this Title, including the Office of Group Benefits.

(13) "Minimal benefit hospital and medical policy" means a policy that provides a fixed payment or benefit, not to exceed the cost of the covered health service.

(14) "Network of providers" or "network" means an entity other than a health insurance issuer that, through contracts with health care providers, provides or arranges for access by groups of enrollees or insureds to health care services by health care providers who are not otherwise or individually contracted directly with a health insurance issuer.

(15) "Prime Network" means a network that requires contracted health care providers to accept the amount payable for covered health care services as payment in full for such services.

Added by Acts 2003, No. 528, §1, eff. June 24, 2003; Acts 2004, No. 493, §1, eff. June 25, 2004.

CHAPTER 9. LOUISIANA AUTOMOBILE THEFT AND INSURANCE FRAUD PREVENTION AUTHORITY

§3201. Definitions

As used in this Chapter:

(1) "Authority" means the Louisiana Automobile Theft and Insurance Fraud Prevention Authority.

(2) "Board" means the board of directors of the Louisiana Automobile Theft and Insurance Fraud Prevention Authority.

(3) "Fund" means the automobile insurance theft and fraud prevention fund administered by the board of directors as a dedicated fund in the state treasury.

(4) "Motor vehicle" means every automobile or other motor vehicle which is self-propelled, other than trains and those propelled by electric power from overhead wires.

Added by Acts 2004, No. 711, §1, eff. August 15, 2004.

§3202. Authority; creation, powers

A. There is hereby created a public agency to be known as the Louisiana Automobile Theft and Insurance Fraud Prevention Authority, the purpose of which is to combat motor vehicle insurance fraud, including fraud by theft and other criminal acts.

B. The purposes, powers and duties of the authority shall be vested in and exercised by a board of directors.

C. The board of directors shall consist of the commissioner of insurance or his designee, the state treasurer or his designee, a representative of the Louisiana State Police Insurance Fraud unit, the chairman of the Senate Committee on Insurance or his designee, the chairman of the House Committee on Insurance or his designee, and six members to be appointed as follows: four members shall be appointed by the commissioner, including two members representing purchasers of motor vehicle insurance in this state and two members representing motor vehicle insurers doing business in this state. Two members shall be appointed by the attorney general, both of whom shall represent law enforcement officials in this state. The commissioner shall serve as chairperson of the authority.

D. The members of the board of directors, except the commissioner of insurance or his designee, the state treasurer or his designee, the representative of the Louisiana State Police Insurance Fraud unit, and the legislative members serving on the board, shall not be considered public employees by virtue of their service on the board of directors.

E. Members of the board shall serve without compensation for their service on the board, except that members of the board may receive reasonable reimbursement for necessary travel and expenses.

F. A majority of the members of the board shall constitute a quorum for the transaction of business at a meeting, or the exercise of a power or function of the authority. Notwithstanding any other law to the contrary, any action may be taken by the authority at a meeting upon a vote of the majority of the members present. The authority shall meet at the call of the chairperson or as may be provided in the bylaws of the authority. Meetings of the authority may be held anywhere within the state, and shall be open public meetings.

G.(1) The authority shall be within the Department of Insurance.

(2) A director and assistant director shall be selected by the board and serve at the pleasure of the commissioner of insurance, shall be considered public employees, and shall operate the daily affairs of the authority as specified herein and by the board.

(3) The attorney general or his designee shall serve as the authority's legal counsel.

H. The authority shall be subject to the provisions of law regarding public records (R.S. 44:1 et seq), open meetings (R.S. 42:4.2 et seq), and public bid (R.S. 38:2211 et seq).

Added by Acts 2004, No. 711, §1, eff. August 15, 2004.

§3203. Authority; further powers and duties

The authority shall have the powers necessary and convenient to implement and effectuate the purposes and provisions of this Chapter and the purposes of the authority and the powers delegated by other laws, including but not limited to the power to:

(1) Sue and be sued; have perpetual succession; make, execute and deliver contracts, conveyances, and other instruments necessary and convenient to the exercise of its powers; and to make and amend its bylaws by a majority vote of the board.

(2) Solicit and accept gifts, grants, donations, loans, and other assistance from any person or entity, private or public, or the federal, state, or local governments or any agency thereof, said gifts, grants, donations, loans, and other assistance to be immediately deposited upon receipt into the fund described in R.S. 22:3204(A).

(3) Establish programs in conjunction with other state agencies, local governing authorities, and law enforcement agencies for motor vehicle theft and insurance fraud prevention, detection and enforcement, which shall include the Attorney General's Criminal Division and Investigation Division.

(4) Make grants to other state agencies, local governing authorities, and law enforcement agencies for motor vehicle theft and insurance fraud prevention, detection and enforcement.

(5) Procure insurance against any loss in connection with its property, assets or activities.

(6) Deposit all monies received for the purposes of this Chapter into the Automobile Theft and Insurance Fraud Prevention Authority Fund, provided for in R.S. 22:3204.

(7) Contract for goods and services and engage personnel as is necessary, including the services of private consultants, auditors, and others for rendering professional services, as provided by law, payable out of any money of the fund legally available for such purpose. Additionally, the board may authorize the attorney general to contract for the services of ad hoc prosecutors or other legal assistance, payable out of any money of the fund legally available for such purpose.

(8) Indemnify and procure insurance indemnifying the members of the board from personal loss from liability resulting from an action or inaction of the board.

(9) Do all other things necessary and convenient to achieve the objectives and purposes of the authority of this Chapter.

Added by Acts 2004, No. 711, §1, eff. August 15, 2004.

§3204. Automobile Theft and Insurance Fraud Prevention Authority Fund

A. There is hereby established a fund in the state treasury to be known as the "Automobile Theft and Insurance Fraud Prevention Authority Fund," hereafter referred to as the "fund," into which the state treasurer shall each fiscal year deposit the revenues received from those sources provided for by this Chapter and other sources as provided for by law after those revenues have been deposited in the Bond Security and Redemption Fund. Out of the funds remaining in the Bond Security and Redemption Fund after a sufficient amount is allocated from that fund to pay all obligations secured by the full faith and credit of the state that become due and payable within each fiscal year, the treasurer, prior to placing such funds in the state general fund, shall pay into the fund an amount equal to the revenue generated from collection from those sources provided for by this Chapter and other sources as provided for by law. No expenditures shall be made from the fund unless first appropriated by the legislature. The monies in the trust fund shall be invested by the state treasurer in the same manner as monies in the state general fund. All interest earned on money from the fund and invested by the state treasurer shall be credited to the Automobile Theft and Insurance Fraud Prevention Authority Fund.

B. Any monies in the Automobile Theft and Insurance Fraud Prevention Authority Fund shall be administered only by the director of the authority, upon a majority vote of the board, in the following order of priority:

(1) To pay the costs of administration of the authority.

(2) To pay the costs of legal counsel.

(3) To achieve the purposes and objectives of this Chapter, which may include but not be limited to the following:

(a) Providing financial support to state or local law enforcement agencies, including but not limited to the office of attorney general, for motor vehicle theft and insurance fraud prevention, detection and enforcement.

(b) Providing financial support to state or local law enforcement agencies, including but not limited to the office of attorney general, for programs designed to reduce the incidence of motor vehicle theft and insurance fraud.

(c) Providing financial support to state and local prosecutors, including but not limited to the office of attorney general, for programs designed to reduce the incidence of motor vehicle theft and insurance fraud.

(d) Conducting educational programs designed to inform motor vehicle owners of methods of preventing motor vehicle theft and insurance fraud.

C. All monies in the Automobile Theft and Insurance Fraud Prevention Authority Fund shall be used only to enhance fraud prevention efforts as determined by the board.

Added by Acts 2004, No. 711, §1, eff. August 15, 2004.

§3205. Plan of operation

A. The authority shall develop and implement a plan of operation upon the recommendations of the director no later than the first of January 2005.

B. The plan of operation shall include an assessment of the scope of the problem of motor vehicle theft and insurance fraud, including a determination of particular areas of the state where the problem is most severe, an analysis of various methods of combating the problem of motor vehicle theft and insurance fraud, a plan for providing financial support for efforts to combat motor vehicle theft and insurance fraud, and an estimate of funds required to implement the plan.

C. The authority shall report annually on or before March first to the House Committee on Insurance and the Senate Committee on Insurance on its activities in the preceding year.

Added by Acts 2004, No. 711, §1, eff. August 15, 2004.